

**FRAMEWORK FOR ANNUAL REPORT
OF STATE CHILDREN'S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT**

Preamble

Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist states in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with states to develop a framework for the Title XXI annual reports.

The framework is designed to:

- C Recognize the *diversity* of State approaches to SCHIP and allow States *flexibility* to highlight key accomplishments and progress of their SCHIP programs, **AND**
- C Provide *consistency* across States in the structure, content, and format of the report, **AND**
- C Build on data *already collected* by HCFA quarterly enrollment and expenditure reports, **AND**
- C Enhance *accessibility* of information to stakeholders on the achievements under Title XXI.

**FRAMEWORK FOR ANNUAL REPORT
OF STATE CHILDREN'S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT**

State/Territory: State of Washington
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

(Signature of Agency Head)

SCHIP Program Name (s): Washington State Children's Health Insurance Program

SCHIP Program Type: _____ Medicaid SCHIP Expansion Only
 X Separate SCHIP Program Only
 _____ Combination of the above

Reporting Period: **Federal Fiscal Year 2000 (10/1/99-9/30/00)**
***This report reflects eight months of activities since
Washington's SCHIP began enrolling children in February 2000.**

Contact Person/Title: Richard Pannkuk, SCHIP Coordinator

Address: Department of Social and Health Services
Medical Assistance Administration
PO Box 45536
Olympia, WA 98504

Phone: (360) 725-1715 Fax: (360) 664-0408

Email: Pannkre@DSHS.WA.GOV

State of Washington
SCHIP Annual Report
January 31, 2001

Submission Date:

December 29, 2000

SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

This sections has been designed to allow you to report on your SCHIP program's changes and progress during Federal fiscal year 2000 (September 30, 1999 to October 1, 2000).

1.1 Please explain changes your State has made in your SCHIP program since September 30, 1999 in the following areas and explain the reason(s) the changes were implemented.

Note: If no new policies or procedures have been implemented since September 30, 1999, please enter 'NC' for no change. If you explored the possibility of changing/implementing a new or different policy or procedure but did not, please explain the reason(s) for that decision as well.

- | | |
|--|----|
| 1. Program eligibility | NC |
| 2. Enrollment process | NC |
| 3. Presumptive eligibility | NC |
| 4. Continuous eligibility | NC |
| 5. Outreach/marketing campaigns | NC |
| 6. Eligibility determination process | NC |
| 7. Eligibility redetermination process | NC |
| 8. Benefit structure | NC |
| 9. Cost-sharing policies | NC |
| 10. Crowd-out policies | NC |
| 11. Delivery system | NC |
| 12. Coordination with other programs (especially private insurance and Medicaid) | NC |
| 13. Screen and enroll process | NC |
| 14. Application | NC |

1.2 Please report how much progress has been made during FFY 2000 in reducing the number of uncovered, low-income children.

1. Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2000. Describe the data source and method used to derive this information.

As noted in our state plan, Washington State will report on the number of SCHIP enrolled children on an annual basis. The number and percentage of uninsured children between 200% and 250% of FPL will be reported on a biennial basis using Washington State Population Survey (WSPS) data. The next WSPS is due January 2001.

In February we had 481,211 children in all programs categories and in September 502,676. That's an increase of 21,465 (4%) since SCHIP and the Healthy Kids Now! public information campaign began in mid-February.

Based on the Office of Financial Management's 1998 Washington State Population Survey, it is estimated that about 125,000 (7.8%) of the state's children were uninsured at the date (March/April 1998) of the survey. Approximately 14,300 (8.2%) of the 175,800 children in households with incomes between 200% and 250% of the federal poverty level (FPL) would have been eligible for SCHIP coverage. The state's children population increased about 1.5% between the WSPS survey and the start of Washington's SCHIP in February 2000. Using this adjustment factor, we estimate there are about 14,500 uninsured SCHIP eligible children at the start of Washington's program. This estimate is higher than the estimated 10,000 uninsured SCHIP eligible children submitted in Washington's June 29, 1999, SCHIP State Plan application. The June 1999 data was based on an earlier release of the 1998 WSPS data. The reason these estimates differ is that the earlier version of the 1998 WSPS understated the total number of children in the state by about 88,000, due to weighting factors used in the survey sample data to project total population estimates. The SCHIP baseline estimate of 14,500 is based on a revised July 1999 release of the WSPS data, which corrects for this weighting factor and includes other adjustments for missing data. Washington did not submit a 1998 annual report because its SCHIP State Plan approval was not obtained until September 1999, and the program did not start to enroll children until February 1, 2000.

Washington has used its biennial WSPS survey to make its baseline estimates. We will use this source to measure subsequent changes in the number and percentage of children who have insurance coverage over time.

2. How many children have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information.

On February 1, 2000, we had 481,211 kids in all program categories and on September 30, 2000, there were 502,676 children in Medicaid. There has been a **21,465** (10%) increase in Medicaid children since the statewide Healthy Kids Now! (HKN!) public awareness campaign began along with the formal SCHIP launch in late February 2000. The HKN! campaign is aimed at families who are eligible for all of the state's children programs and works closely with and supports already existing outreach activities.

3. Please present any other evidence of progress toward reducing the number of uninsured, low-income children in your State.

The Urban Institute reports in *Snapshots of America's Families II* (October 2000) that the total number of uninsured, low-income children in the state dropped from 13.6% in 1997 to 11.2% in 1999.

Apart from this report, and as of September 30, 2000, there are 2,662 children enrolled in the SCHIP, averaging 333 children each month.

4. Has your State changed its baseline of uncovered, low-income children from the number reported in your March 2000 Evaluation?

 X No, skip to 1.3

 Yes, what is the new baseline?

What are the data source(s) and methodology used to make this estimate?

What was the justification for adopting a different methodology?

What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Had your state not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

1.3 Complete Table 1.3 to show what progress has been made during FFY 2000 toward achieving your State's strategic objectives and performance goals (as specified in your State Plan).

In Table 1.3, summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as

State of Washington
SCHIP Annual Report
January 31, 2001

specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

- Column 1: List your State's strategic objectives for your SCHIP program, as specified in your State Plan.
- Column 2: List the performance goals for each strategic objective.
- Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, denominator). Please attach additional narrative if necessary.

*Note: If no new data are available or no new studies have been conducted since what was reported in the March 2000 Evaluation, please complete columns 1 and 2 and enter **ANC** (for no change) in column 3.*

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
To reduce the percentage of uninsured children between 200% and 250% of FPL.	Reduce the percentage of uninsured children between 200% and 250% of FPL.	Data Sources: NC Methodology: Progress Summary:
OBJECTIVES RELATED TO SCHIP ENROLLMENT		
To increase the number of children in households between 200% and 250% of FPL who have health insurance coverage.	Increase the number of children between 200% and 250% of FPL who have health care coverage. Reduce the percentage of uninsured children between 200% and 250% of FPL.	Data Sources: NC Methodology: Progress Summary:

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT		
To increase the number of low-income children in households below 200% of the FPL who have health insurance coverage	<p>Increase the number of children below 200% FPL, who have health coverage.</p> <p>Increase the percentage of children below 200% FPL, who have health coverage.</p>	<p>Data Sources: NC</p> <p>Methodology:</p> <p>Progress Summary:</p>
OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)		
		<p>Data Sources:</p> <p>Methodology:</p> <p>Progress Summary:</p>
OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)		

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
	Track the satisfaction and health care of SCHIP children compared to Medicaid children and non-Medicaid children.	<p>Data Sources: NC</p> <p>Methodology:</p> <p>Progress Summary:</p>
OTHER OBJECTIVES		
		<p>Data Sources:</p> <p>Methodology:</p> <p>Progress Summary:</p>

1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them.

As noted in the State Plan, the state of Washington and the Governor's Office of Financial Management (OFM) Forecast Section will analyze WSPS data to measure the number and percentage of children who are uninsured. The WSPS is a comprehensive survey conducted under contract with the Washington State University's Social and Economic Sciences Research Center. The survey is modeled after U.S. Bureau of the Census's Current Population Survey (CPS). However, the survey is a statewide survey with a greatly enhanced sample size (6,950 households in 1998) to allow for statistically reliable analyses for the state and regions within the state. There are expanded samples of racial and ethnic minorities to be able to compare socio-economic characteristics of people of different racial and ethnic backgrounds. Since the WSPS is conducted biennially, the SCHIP uninsured performance measures will be reported every two years.

1.5 Discuss your State's progress in addressing any specific issues that your state agreed to assess in your State plan that are not included as strategic objectives.

In our State Plan we agreed to assess the effects of premiums on participation and the effects of cost sharing on utilization. We anticipate this can be accomplished for the next annual report.

1.6 Discuss future performance measurement activities, including a projection of when additional data are likely to be available.

We expect to obtain the WSPS data sometime after the first of the year and HEDIS data in January 2002. At that time we will closely review this data and compare the findings with the Strategic Objectives and Performance Goals we set. Our findings will be reported in the next annual report.

1.7 Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here.

We have attached two documents that address various performance aspects of our SCHIP program. The first is a study conducted by **Robinson Research, Inc.** The purpose of the study was to determine attitudes and perceptions regarding health care coverage in Washington State. The second document is an outreach document that details the SCHIP marketing campaign plan to enroll all eligible children.

Document 1

TO: Advisory Council Members
FR: Michelle Hege and Cher Desautel, Desautel Hege Communications
Deanna Davis, Health Improvement Partnership
RE: Statewide consumer report survey significant conclusions

As you know, as part of our research we commissioned Robinson Research, Inc. to conduct a 400-sample consumer survey. The purpose of the study was to determine attitudes and perceptions regarding health care coverage in Washington state. Calls were conducted between the dates of December 14, 1999 and January 8, 2000. The sampling was representative of the population statewide, with a somewhat greater emphasis on sampling rural populations. All respondents were screened to be within the CHIP/Medicaid income guidelines and have children under 19 living in their household. This 400-sample survey has a margin of error of +/-4.9%.

Following are some significant conclusions that were discovered from this survey.

- *In general, respondents did not know that their children could qualify for health insurance.* This confirms the importance of getting the word out about the program and making people aware that there are health care options for children.
- *If respondents knew about state-sponsored health insurance for children, they were willing to apply for it.* This indicates that once people are aware, they are receptive to applying.
- *Most households in the sample were working families.* Nearly three-fourths (73%) were employed. Therefore, the marketing campaign is correct to target working families.
- *Expense is the biggest reason for not having health insurance.* Again, the marketing campaign is on track by emphasizing free or low-cost health insurance as a key message.
- *If the head of the household was uninsured, a high likelihood existed that their children were also uninsured.*
- *Five percent of the total sample had uninsured children.* This percentage is slightly lower than other statewide statistics show. According to the Human Services Policy Center, 7.8% of Washington State residents, under 19 are uninsured. 1

1 Taken from State of Washington's Children – Winter 1999, Statewide Summary of Child and Family Well Being Profiles by County, Human Services Policy Center, University of Washington, www.hspc.org.
State of Washington
SCHIP Annual Report
January 31, 2001

Desautel Hege Communications

Children's Health Insurance Program (CHIP) Study

Summary Report

January 2000

Prepared by:

Robinson Research, Inc.
524 West Indiana Avenue
Spokane, Washington 99205

State of Washington
SCHIP Annual Report
January 31, 2001

Phone: (509) 325-8080
Fax: (509) 325-8068
E-mail: robinsonresearch@icehouse.net

Table of Contents

Statement of Methodology	15
Summary	18
Addendum.....	30

STATEMENT OF METHODOLOGY

Statement of Methodology

Robinson Research, Inc. was commissioned by Desautel Hege Communications to conduct a 400-sample Image Assessment Study. The purpose of this study was to determine attitudes and perceptions regarding healthcare coverage in Washington State.

Calls were conducted between the dates of December 14, 1999 and January 8, 2000. No fewer than fifteen percent (15%) of the interviews were monitored in their entirety, and an additional ten percent (10%) were called back by a supervisor for verification of key points of the data. Standard dialing protocols were established. Approximately five attempts were made on each number during evening and weekend hours (unless the interview was refused or completed with fewer attempts) before a replacement number was issued.

Participants were screened to not be employed in a critical industry (public relations or market research firm, a state-owned organization, or for a health care provider), to have children under the age of nineteen, to support children under the age of nineteen, and to have before-tax monthly household incomes up to 300% over the Federal Poverty Level.

A 400-sample survey has a margin of error of +/- 4.9%, which means that, in theory, results have a ninety-five percent chance of coming within +/- 4.9 percentage points of results that would have been obtained had all potential respondents been interviewed.

Following are the sample sizes and margins of error for the television coverage areas sampled:

Area	Sample Size	Margin of Error
Seattle	256	+/- 6.1%
Spokane	78	+/- 11.1%
SW Counties (Portland TV)	32	+/- 17.3%
Tri-Cities	18	+/- 23.1%
Yakima	16	+/- 24.5%
Total	400	+/- 4.9%

The sampling was representative of the population statewide, with some over-emphasis on sampling rural populations.

Statement of Methodology (continued)

The following shows the percentage of sample sizes within each county.

• Adams	1 complete	• Kittitas	1%
• Asotin	1%	• Klickitat	1%
• Benton	2%	• Lewis	2%
• Chelan	2%	• Mason	1%
• Clallam	2%	• Okanogan	1%
• Clark	6%	• Pacific	1%
• Columbia	1 complete	• Pierce	11%
• Cowlitz	2%	• San Juan	1 complete
• Douglas	1%	• Skagit	2%
• Ferry	1 complete	• Snohomish	9%
• Franklin	1%	• Spokane	13%
• Garfield	1 complete	• Stevens	1%
• Grant	2%	• Thurston	4%
• Grays Harbor	2%	• Walla Walla	1%
• Island	1%	• Whatcom	3%
• Jefferson	1%	• Whitman	1%
• King	21%	• Yakima	4%
• Kitsap	4%		

The data were tabulated using Robinson Research systems. Questions regarding this study may be directed to:

William D. Robinson
President
Robinson Research, Inc.
524 West Indiana Avenue
Spokane, Washington 99205
Phone: (509) 325-8080
Fax: (509) 325-8068
E-mail: robinsonresearch@icehouse.net

DETAILED OBSERVATIONS

Q.1 To the best of your knowledge, what would you consider to be your primary source of health insurance information?

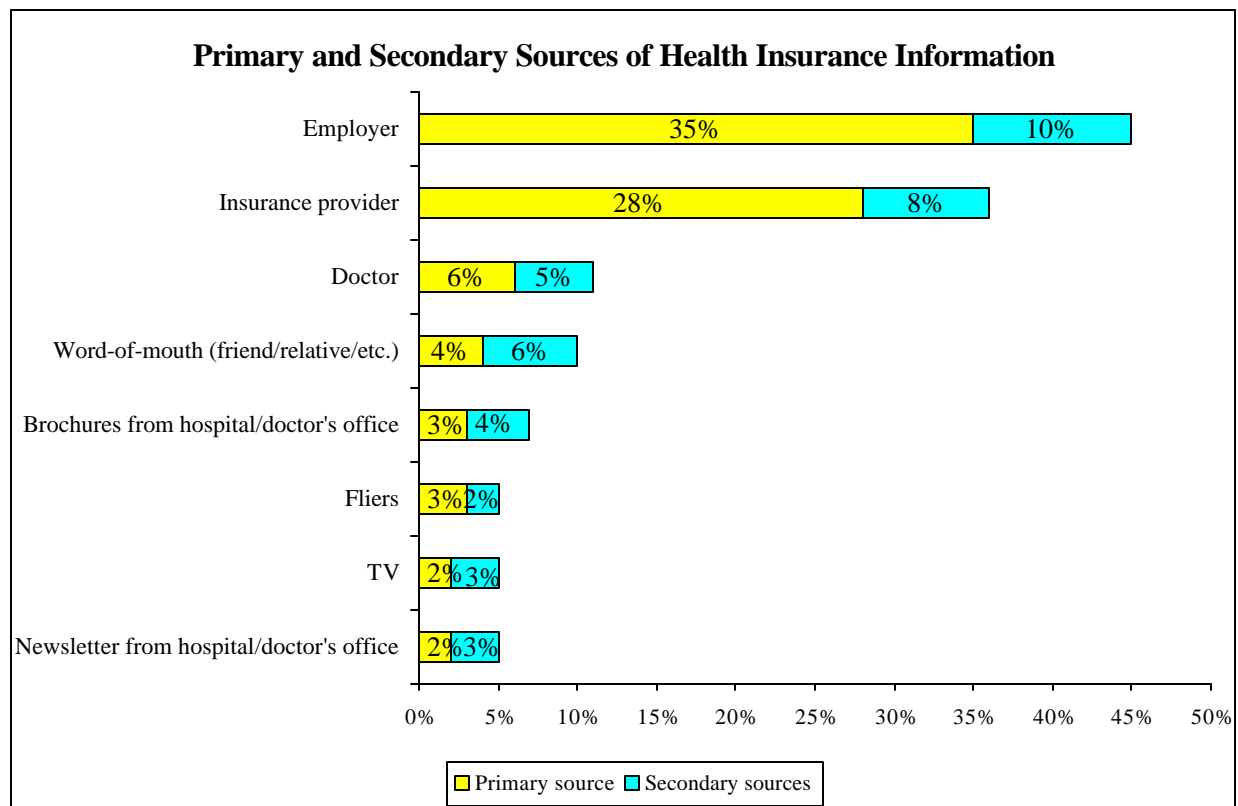
This question was asked of all respondents in an unaided manner. Participants were not read a list from which to select a response.

Employers (35%) and insurance providers (28%) were, by far, the dominant primary sources of information about health insurance. Doctors were a distant third at six percent (6%). No other single source was cited by more than four percent (4%).

Q.2 The next question deals with health insurance. We define health insurance as any health care coverage you have through any private insurance company such as Blue Cross or Group Health or through a Washington State health insurance program such as Medicaid, Medicare, or Basic Health Plan. What other sources do you use for your health insurance information?

All respondents were asked this unaided question. Multiple responses were allowed.

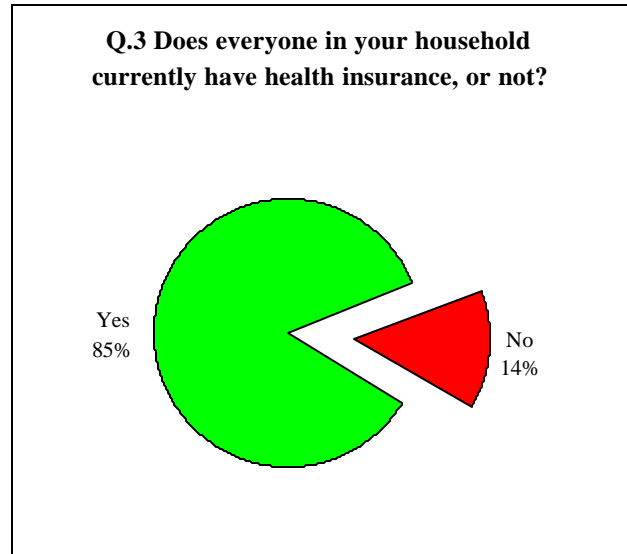
When primary and secondary information sources are combined, we see the following:



Q.3 Does everyone in your household currently have health insurance, or not?

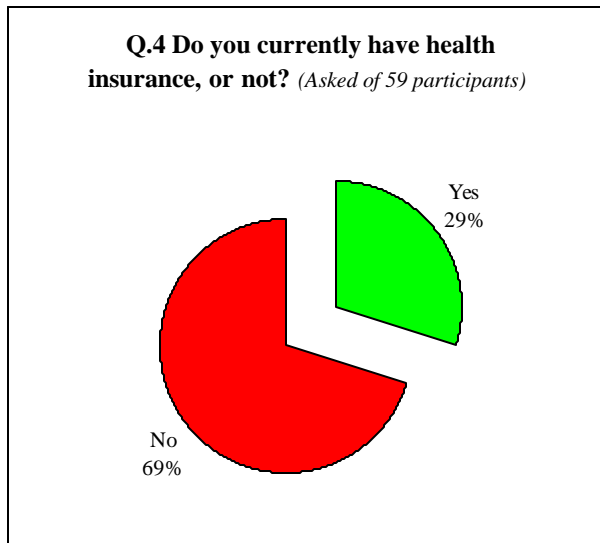
All 400 respondents were asked this question.

Eighty-five percent (85%) indicated that all household members had health care insurance.



Q.4 Do you currently have health insurance, or not?

Only the fifty-nine who indicated that not all household members were insured were asked this question.



When viewed as a percentage of the overall sampling (n=400), we see that one in ten (10%) of the qualifying heads of households had no health care insurance.

The smaller the household, the greater the likelihood that the responding head of the household would be uninsured.

Q.5 Do you think you will be maintaining your health insurance for the next 12 months?

This question was asked of the 359 who reported having insurance on themselves in previous questions.

Nearly all (97%) believed that they would continue to be insured over the next twelve months.

Q.6 For what reasons will you NOT be maintaining your health insurance?

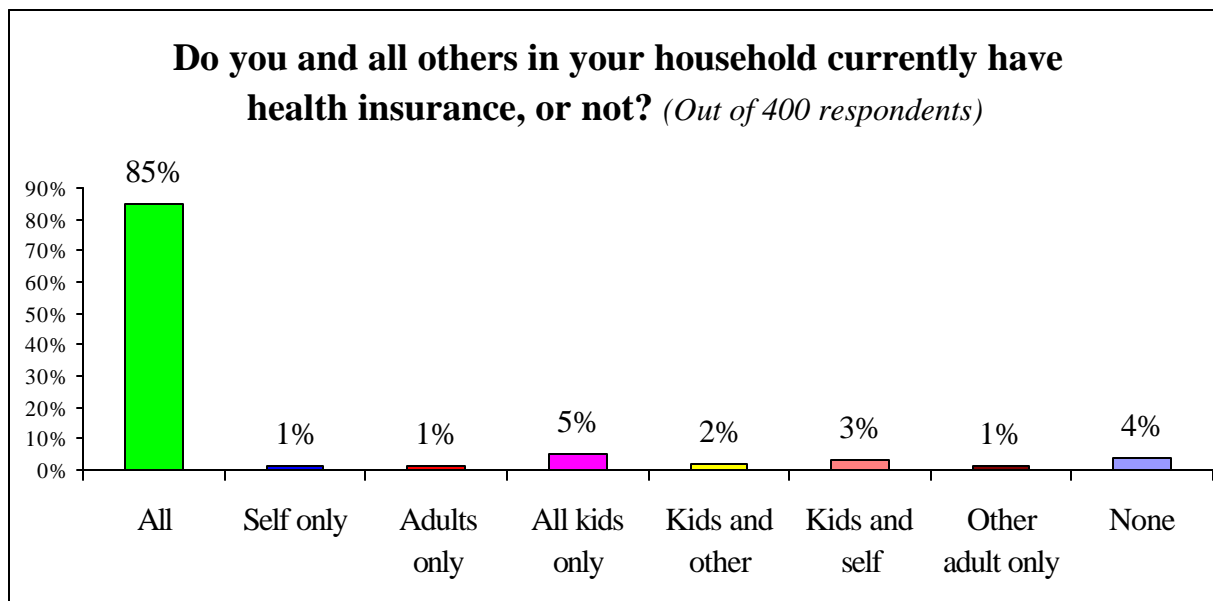
Only six participants who had health care insurance, but anticipated not maintaining it for the next twelve months were asked this question.

Five respondents claimed they would not be maintaining health insurance because it was unaffordable. One mentioned a loss of employment.

Q.7 Do all the other adults in your household currently have health insurance, or not?

This question was asked of the fifty-nine who did not indicate that all household members had health care insurance.

When viewed as a percentage of the households with more than one adult, we see that thirty-six households (11% of 343) reported one or more adults (not counting the respondent) with no health care insurance. The graph below shows the distribution of health insurance coverage.



Q.8 Do all the dependent children under the age of nineteen currently have health insurance, or not?

This question was asked of the fifty-nine who did not indicate that all household members had health care insurance.

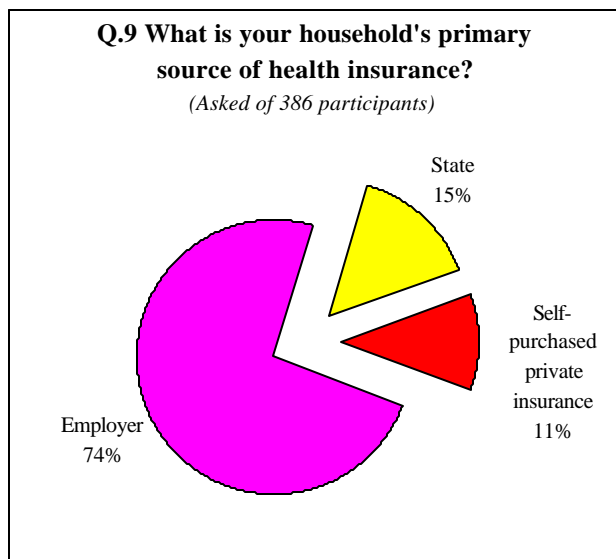
Twenty-one (5%) of the 400 households had dependent children with no health care insurance.

Q.9 What is your household's primary source of health insurance?

This question was asked of the 386 who indicated that one or more household members had health care insurance.

The pie graph to the right shows the distribution of sources of insurance.

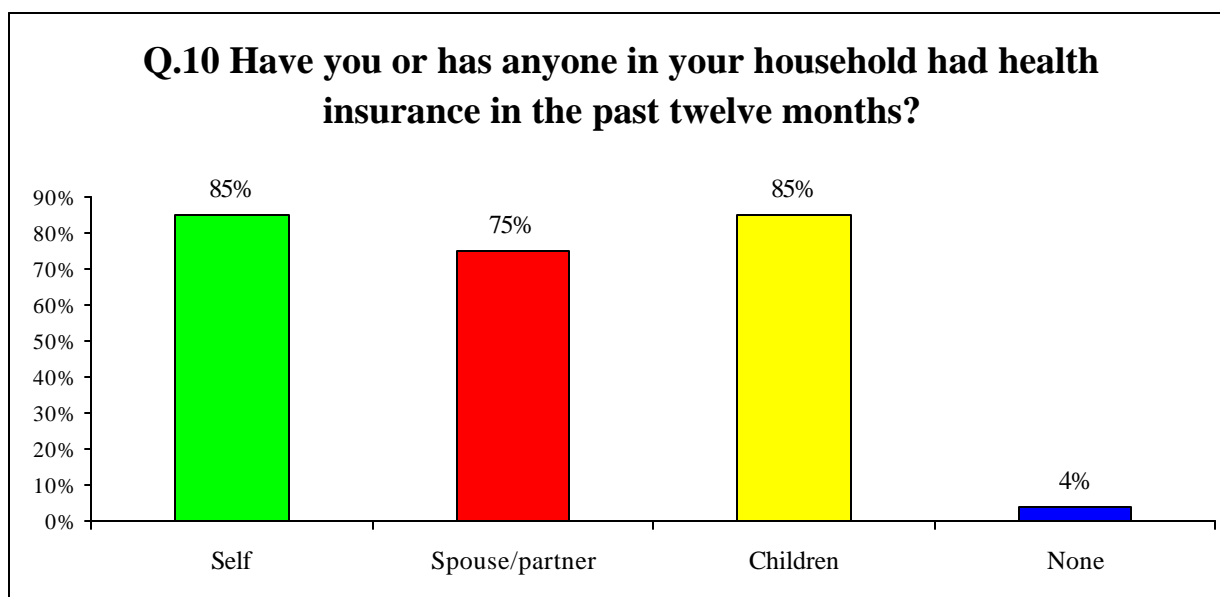
Nearly half (45%) of those who indicated that the state was their primary source were aware of BHP, compared to thirty-seven percent (37%) of those whose employer was the primary source.



Q.10 Have you or has anyone in your household had health insurance in the past twelve months?

This question was asked of all respondents.

All but fourteen (4%) of the households had at least one household member with health care insurance in the past twelve months. The graph below shows the distribution of responses.



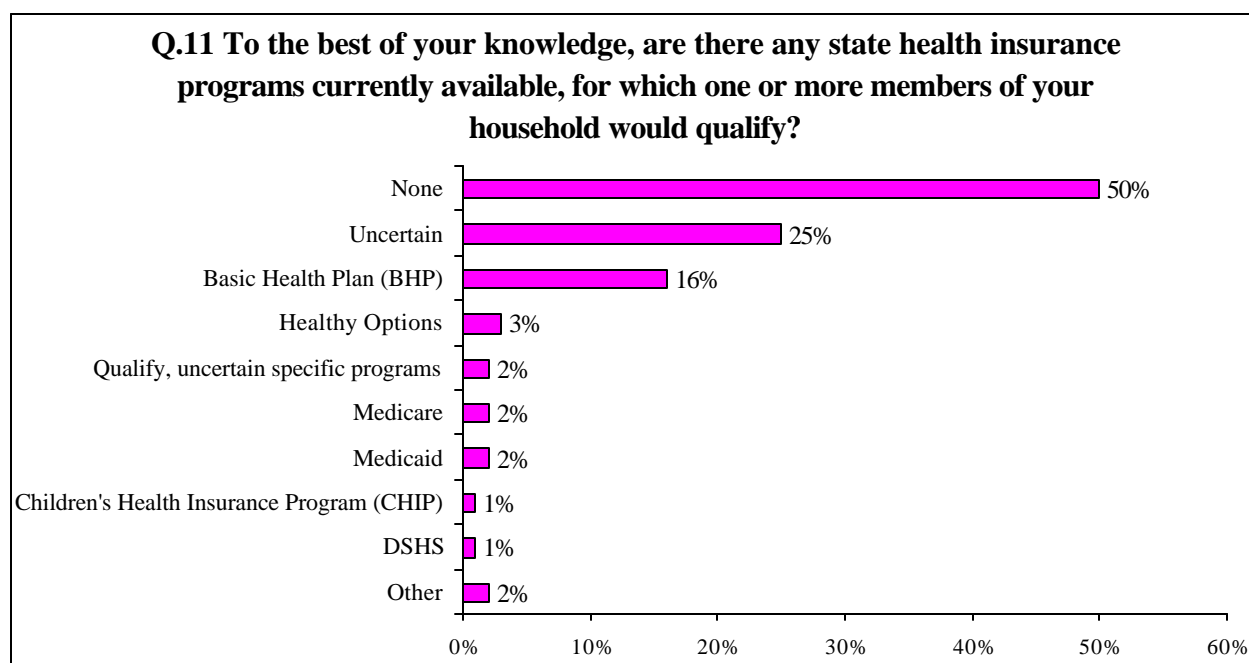
Of the fourteen households with no one currently insured, nine had at least one household member who

was insured in the past twelve months.

Q.11 To the best of your knowledge, are there any state health insurance programs currently available, for which one or more members of your household would qualify?

All 400 respondents were asked this unaided question. Multiple responses were allowed.

Three-fourths (75%) demonstrated no awareness of state health insurance programs. The following graph shows the distribution of responses:



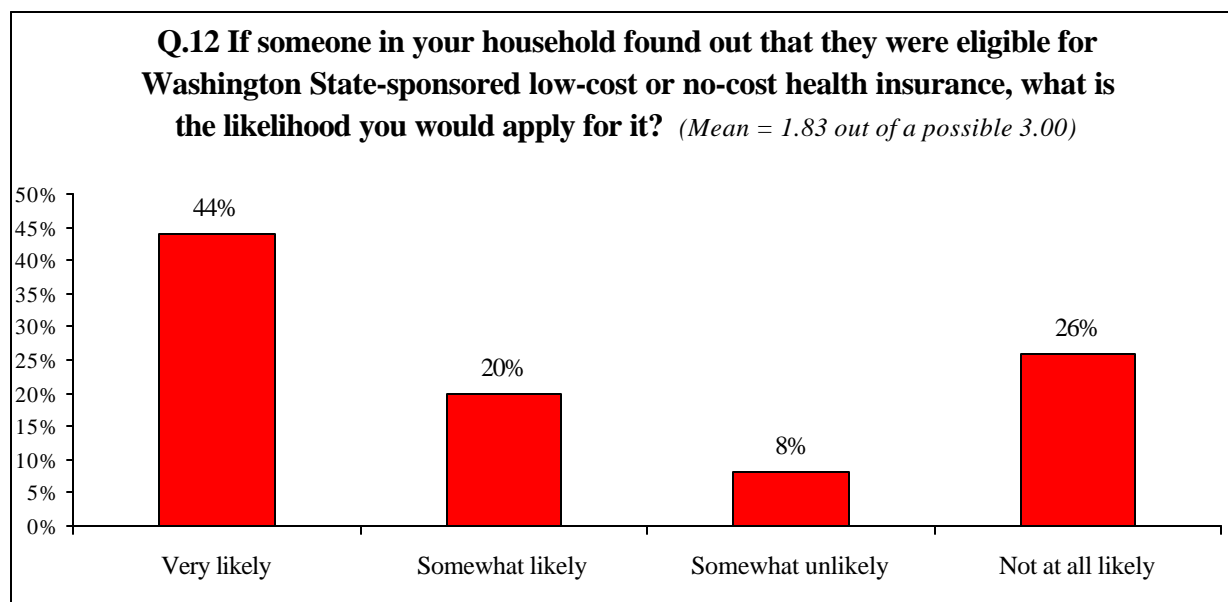
Those with only one adult in the household were considerably more likely than average to name BHP.

Q.12 If someone in your household found out that they were eligible for Washington State-sponsored low-cost or no-cost health insurance, what is the likelihood you would apply for it? Would you say very likely, somewhat likely, somewhat unlikely, or not at all likely?

This question was asked of all 400 respondents.

Nearly two-thirds (64%) would be at least somewhat likely to apply for state-sponsored health insurance.

The following graph shows the distribution of responses.



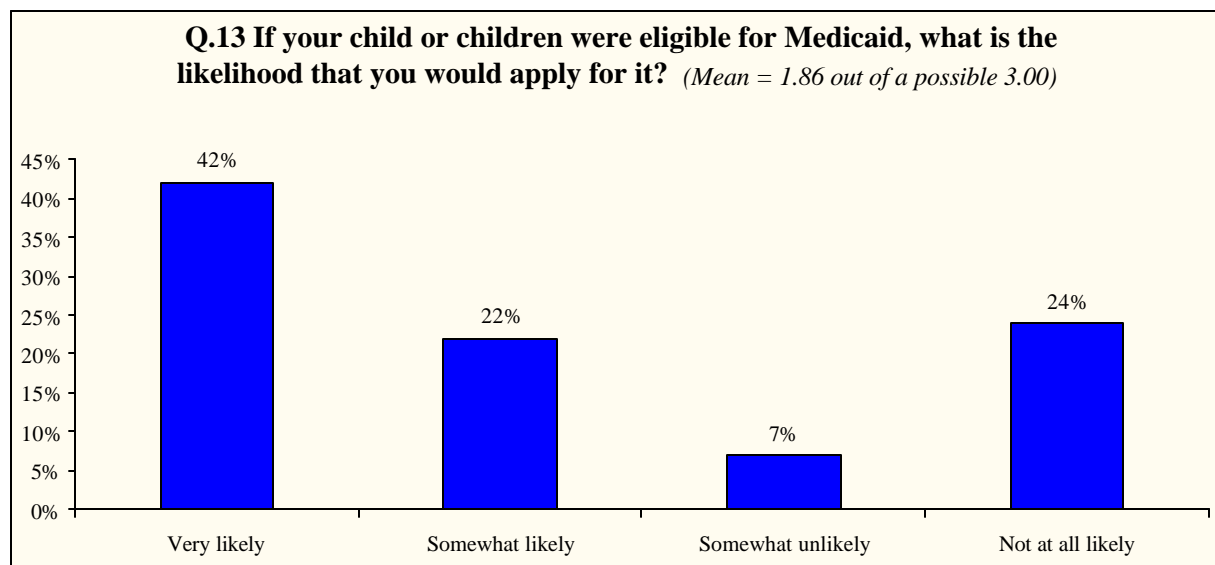
Those with only one adult and those with only two household members were particularly likely to intend to apply. Households with uninsured members were significantly more likely than average to apply.

Q.13 If your child or children were eligible for Medicaid, what is the likelihood that you would apply for it? Would you say very likely, somewhat likely, somewhat unlikely, or not at all likely?

All 400 respondents were asked this question.

Likelihood of applying for Medicaid was slightly higher than likelihood of applying for state-sponsored insurance, but the difference was far from being statistically significant.

The following graph shows the distribution of responses.



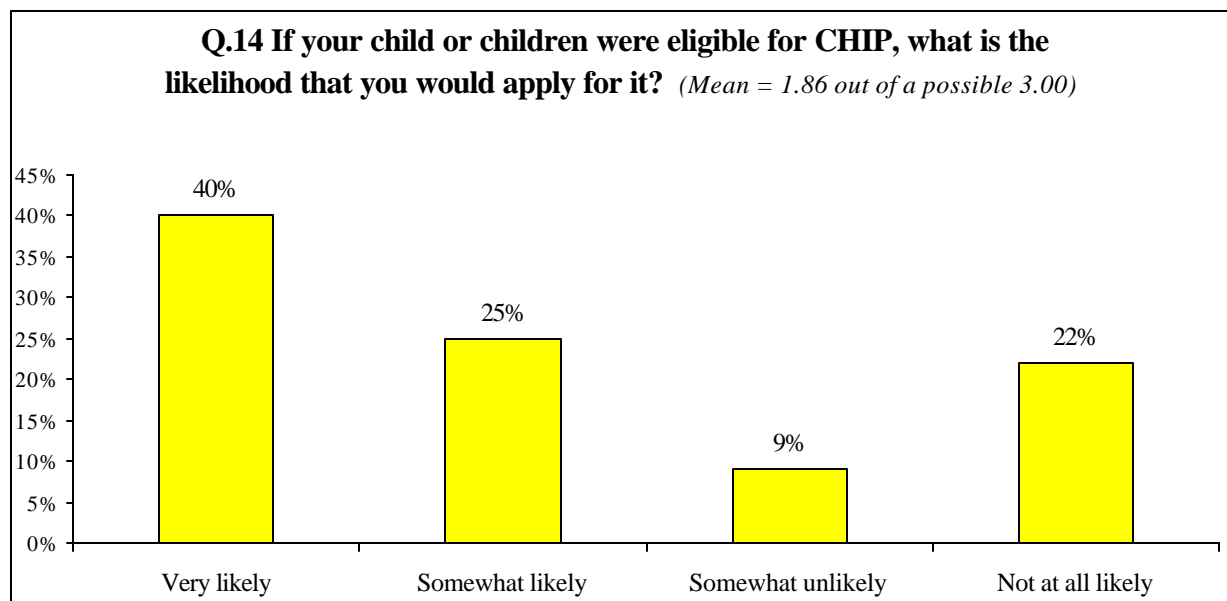
The same subsets that would be particularly likely to apply for state-sponsored insurance were also particularly likely to apply for Medicaid. Households with uninsured children were significantly more likely than average to apply.

Q.14 Children's Health Insurance Program, or CHIP, is a new Washington state low-cost health insurance program for children. If your child or children were eligible for CHIP, what is the likelihood that you would apply for it? Would you say very likely, somewhat likely, somewhat unlikely, or not at all likely?

This question was asked of all respondents.

Likelihood of applying for CHIP was identical to that of Medicaid and very comparable to likelihood of applying for state-sponsored insurance.

The following graph shows the distribution of responses.



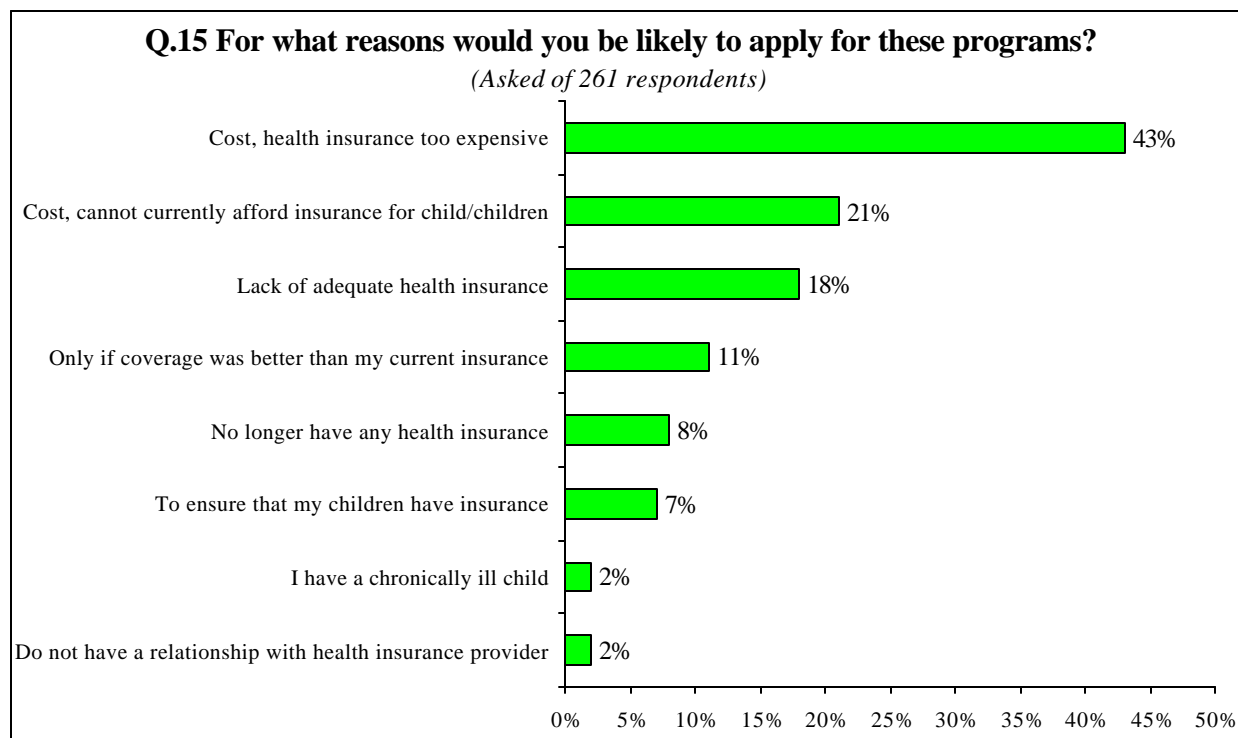
The same subsets that would be likely to apply for one type of insurance would also be likely to apply for the others.

Q.15 For what reasons would you be likely to apply for these programs?

This unaided question was asked of the 261 who would be at least somewhat likely to apply for CHIP. Multiple responses were allowed.

Forty-three percent (43%) would be likely because health insurance was too expensive.

The following graph shows the most commonly cited reasons:



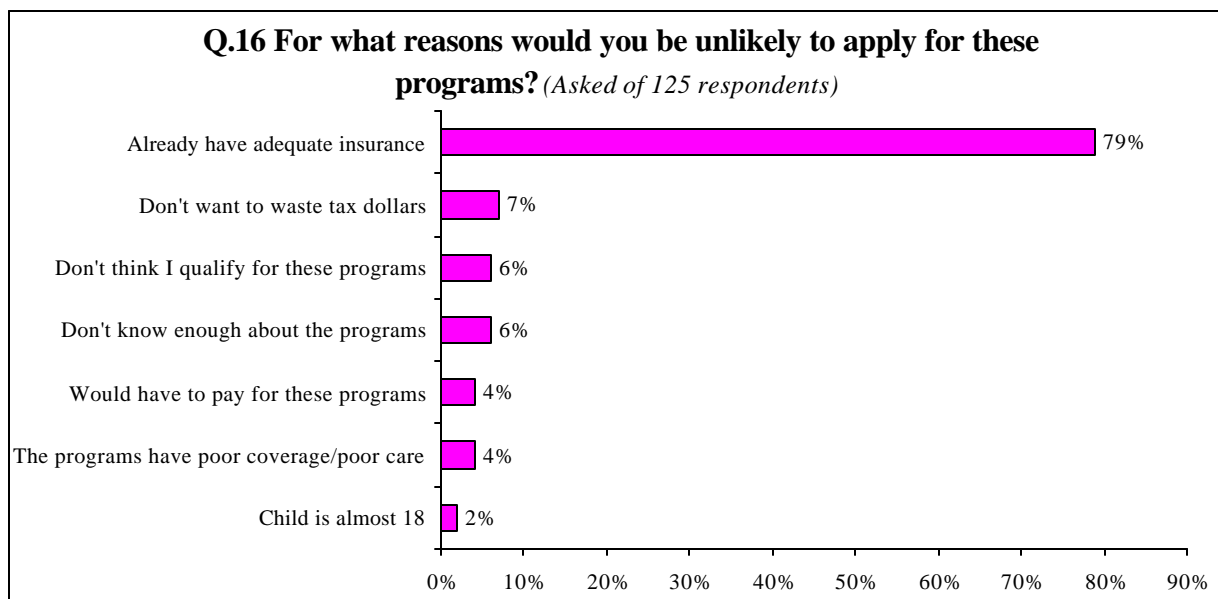
Responses spanned the tested subsets fairly evenly.

Q.16 For what reasons would you be unlikely to apply for these programs?

This question was asked of the 125 who would be unlikely to apply for CHIP. Responses were captured verbatim and subsequently coded for ease of interpretation. Verbatim responses can be found in the addendum to this report.

Four-in-five (79%) claimed to already have adequate insurance or had no need for the programs.

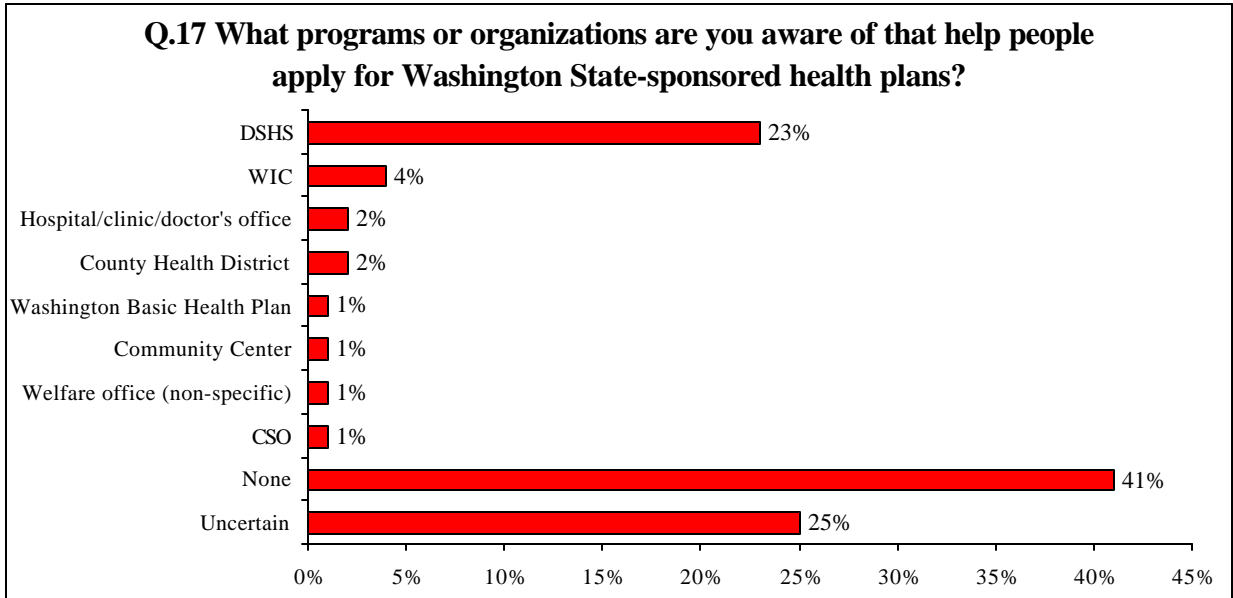
The following graph shows the most commonly cited reasons:



Q.17 What programs or organizations are you aware of that help people apply for Washington State-sponsored health plans?

All 400 participants were asked this unaided question. Multiple responses were allowed.

Two-thirds (66%) were unable to name any programs at all. The following graph shows the most commonly mentioned programs and organizations.



Respondent Profile

- The average age of respondents was 38.70 years, somewhat younger than one would find in a random statewide survey of heads of households.
- One-in-five (21%) were from King County. One-in-eight (13%) were from Spokane County and one in nine (11%) were from Pierce County. One-in-eleven (9%) were from Snohomish County. No other county accounted for more than six percent (6%) of the sampling.
- Four-in-five (81%) were married or living as married.
- Thirty-six percent (36%) described their residence as suburban, thirty-three percent (33%) described it as rural and twenty-nine percent (29%) described it as urban.
- Nearly three-fourths (73%) were employed.
- In the households with a spouse or partner, four-in-five (79%) were employed.
- Among those employed, nearly one-fourth (23%) were employed in government. No other industry was cited by more than fourteen percent (14%).
- Eighty-seven percent (87%) described their ethnicity as White/Caucasian, with Hispanic a distant second at five percent (5%). Three percent (3%) described themselves as American Indian and two percent (2%) described themselves as African-American.
- Two-thirds (66%) were female.

ADDENDUM

Please note that “P/” indicates a probing question was asked by the interviewer and “C/” indicates a clarifying question was asked.

Q.1 To the best of your knowledge, what would you consider to be your primary source if health insurance information?

(Other responses)

BY TELEPHONE. (2 MENTIONS)

COMMUNITY SERVICES.

PUBLIC SCHOOLS. (2 MENTIONS)

Q.2 What other sources do you use for your health insurance information?

(Other responses)

AARP MAGAZINE.

TELEPHONE BOOK.

CALL ON TELEPHONE.

MY OWN RESEARCH.

MAGAZINES.

Q.10 Have you or has anyone in your household had health insurance in the past twelve months?

(Other responses)

GRANDCHILD.

PARENTS.

FATHER.

Q.11 To the best of your knowledge, are there any state health insurance programs currently available, for which one or more members of your household would qualify?

(Other responses)

GROUP HEALTH (2 MENTIONS)

WELL CHILD

HEALTHY KIDS

MEDICAL COUPONS

WASHINGTON EDUCATION
ASSOCIATION

ADOPTION SUPPORT IS OUR
SECONDARY INSURANCE

QUAL-MED

Q.15 For what reasons would you be likely to apply for these programs?

(Other responses)

DEPENDS ON IF WE'RE ABLE TO KEEP
IT. IF IT'S AFFORDABLE AFTER MY
HUSBAND RETIRES.

IF IT'S AVAILABLE, I MAY AS WELL
TAKE ADVANTAGE OF IT.

LOW COST AND HIGH DEDUCTIBLE.

ANYTHING. ANY LITTLE BIT HELPS.

TO SEE IF I WAS ELIGIBLE. IF IT WAS
LESS COMPLICATED THAN CURRENT
COVERAGE.

SELF EMPLOYED.

THEY ARE AVAILABLE.

EDUCATION.

INSURANCE DOES NOT PAY
EVERYTHING. BILLS PILE UP. NO PAY
FOR YEARLY CHECK UPS.

Q.16 For what reasons would you be unlikely to apply for these programs?

I ALREADY HAVE DSHS. HAVE INSURANCE THROUGH MY HUSBAND'S EMPLOYER. WE ARE FORTUNATE ENOUGH TO BE ABLE TO PAY OUR DEDUCTIBLE. WE WOULDN'T NEED OTHER INSURANCE. P/ NO.

IT'S THIEVERY FROM OTHER PEOPLE. THEY TAKE MONEY FROM OUR BUSINESS AND GIVE IT TO FREELoadERS. P/ NO.

I HAVE BETTER HEALTH INSURANCE THROUGH MY EMPLOYER.

I FEEL THAT THE FAMILY SHOULD TAKE CARE OF THEMSELVES, RATHER THAN PAY MORE TAX DOLLARS. C/ IT WAS THE WAY THAT I WAS RAISED. P/ WE DON'T NEED TO SEEK OUTSIDE HELP. MY HUSBANDS INSURANCE COVERS ALL OF OURS. P/ NO.

HAPPY WITH CURRENT COVERAGE.

I HAVE COMPLETE COVERAGE FOR MY FAMILY FROM MY PROVIDER. I SEE NO REASON TO ACCEPT ASSISTANCE FROM THE STATE. P/ NO.

I ALREADY HAVE HEALTH INSURANCE.

I HAVE EXCELLENT INSURANCE. NO NEED FOR THE STATE PROGRAMS.

I HAVE INSURANCE THROUGH MY EMPLOYER.

WE ARE ALREADY COVERED BY MILITARY.

MY HUSBAND IS IN THE US MILITARY.

I THINK OUR CURRENT PROVIDER IS BETTER. P/ I WOULDN'T BE INTERESTED BECAUSE I DON'T KNOW IF I WOULD BE ABLE TO HAVE BOTH. P/ NO OTHER REASONS.

OUR HEALTH INSURANCE IS PAID FOR. C/ MY HUSBAND'S WORK COVERS THE COST. P/ NO.

WE ARE ALREADY COVERED BY INSURANCE. GIVE IT TO SOMEONE WHO NEEDS IT.

WE'RE NOT IN A POSITION WHERE WE NEED TO HAVE THAT KIND OF STATE HELP.

WE DO NOT PAY FOR OUR MEDICAL INSURANCE. MY HUSBAND'S EMPLOYER PAYS FOR IT. WE ONLY PAY A DEDUCTIBLE. P/ NO.

THOUGH IT MIGHT BE CHEAPER, I DOUBT THE COVERAGE IS AS GOOD AS I HAVE NOW. THE SERVICE IS PROBABLY NOT AS GOOD. I MIGHT SAVE SOME MONEY, BUT I'D BE GIVING MYSELF A BIG HEADACHE IN THE LONG RUN. P/ NONE. P/ NO.

I HAVE CURRENT HEALTH INSURANCE. P/ NO.

WE ALREADY HAVE INSURANCE. P/ I DON'T THINK IT WOULD BE FAIR IF WE USED IT WHEN WE DIDN'T NEED IT. IT WOULD BE BETTER TO SAVE IT FOR PEOPLE WHO CAN'T AFFORD IT. P/ NO.

MY CHILD IS ON THE BASIC HEALTH PLAN. I GET IT FOR FREE. WHY WOULD I APPLY FOR LOW COST INSURANCE WHEN I ALREADY GET IT FOR FREE?

MY HEALTH CARE BENEFITS AT WORK ARE GOOD ENOUGH. I WOULDN'T BE INTERESTED IN ANOTHER PLAN. P/ NO.

IT'S NOT NECESSARY. WE ALREADY HAVE HEALTH INSURANCE. P/ NOPE.

I DON'T APPLY FOR STUFF THAT I DON'T KNOW WHAT IT'S ABOUT.

THE CHILDREN GET COMPLETE COVERAGE FROM THEIR FATHER'S EMPLOYER.

I'M HAPPY WITH MY PLAN. MY COVERAGE IS GOOD. I DON'T SEE ANY REASON TO LEAVE. MY COVERAGE IS GOOD. MY PHYSICIAN IS GOOD. THE PRICES AND PREMIUMS ARE LOW. P/ NO.

I'M ALREADY COVERED UNDER ANOTHER PROGRAM.

WE HAVE GOOD HEALTH INSURANCE THROUGH MY HUSBAND'S EMPLOYER. P/ NO.

I HAVE HEALTH INSURANCE. P/ NO.

I HAVE GOOD COVERAGE ALREADY PAID THROUGH MY EMPLOYER. P/ NO.

WITH THE GOVERNMENT, YOU GO THROUGH SO MUCH RED TAPE IT'S UNREAL. IT'S JUST NOT PRACTICAL. YOU HAVE TO SUBMIT INCOME STATEMENTS FOR EACH MONTH. WHEN YOU'RE SELF-EMPLOYED, SOMETIMES YOU HAVE A GOOD MONTH AND SOMETIMES YOU HAVE A BAD MONTH. IT'S NOT RELIABLE. P/ NONE.

I DON'T KNOW ANYTHING ABOUT IT. IF I HAD INFORMATION ABOUT IT, I WOULD BE ABLE TO MAKE THAT DETERMINATION. UNTIL I HAVE MORE INFORMATION, I WOULD BE UNLIKELY TO APPLY FOR IT. P/ NO.

THEY ARE ALREADY COVERED BY EMPLOYER'S INSURANCE THROUGH THE FATHER. P/ NO.

WE ARE MOVING TO ALASKA. P/ NO.

WE WOULD HAVE TO SEE HOW IT WOULD WORK FIRST. P/ NO.

WE HAVE REALLY GOOD COVERAGE RIGHT NOW. P/ NO.

I JUST DON'T BELIEVE WE ARE QUALIFIED FOR ANY LOW INCOME STATE HEALTH PLANS.

HAVE FREE INSURANCE THROUGH MY EMPLOYER

WE ALREADY HAVE A HEALTH INSURANCE PLAN.

THERE IS NO NEED FOR US APPLYING FOR ANY OF THESE PROGRAMS. I AM SATISFIED WITH THE COVERAGE I CURRENTLY HAVE. P/ NO.

I'M SATISFIED WITH WHAT COVERAGE I HAVE. P/ IT SATISFIES OUR NEEDS. P/ NO.

AT THIS POINT, BETWEEN TWO EMPLOYERS I WOULDN'T NEED TO DO THAT. P/ NO.

WE'RE HAPPY WITH WHAT WE HAVE. C/ IT HAS NO FORMS TO FILL OUT. THE BENEFITS ARE GOOD. P/ JUST THE INCONVENIENCE TO DO IT. P/ NOT REALLY.

WE'RE HAPPY WITH GROUP HEALTH. IT'S TOTALLY PAID FOR BY THE UNIVERSITY OF WASHINGTON. THAT'S WHERE WE'VE BEEN FOR 13 YEARS. P/ NO.

I BELIEVE THE BENEFIT PACKAGE I GET FROM MY EMPLOYER IS WHAT I SHOULD USE. I DON'T WANT TO USE TAXPAYER DOLLARS TO FUND SOMETHING I'M ALREADY RECEIVING. P/ NO.

MY INSURANCE COVERS EVERYTHING AT THIS POINT. I DON'T THINK I WOULD BE ELIGIBLE.

IT'S STATE SPONSORED.

SATISFIED WITH THE PROGRAM WE HAVE RIGHT NOW THROUGH MY EMPLOYER.

I ALREADY GET REALLY GOOD HEALTH INSURANCE THROUGH MY EMPLOYER.

WE ALREADY HAVE GOOD HEALTH INSURANCE AND ARE SATISFIED. P/ NO.

MY SON IS ALMOST 18 NOW. P/ NO.

HE'S ALREADY DOUBLE INSURED THROUGH BOTH ME AND MY HUSBAND. P/ NO.

AT PRESENT, I DON'T NEED THEM. WE HAVE ADEQUATE INSURANCE ALREADY. P/ I
DON'T HAVE ENOUGH INFORMATION ABOUT THEM. P/ I THINK THAT'S BASICALLY
IT. P/ NO.

WE HAVE VERY GOOD COVERAGE WITH OUR EMPLOYER INSURANCE. P/ WHAT
WE'RE PAYING NOW IS VERY LOW. P/ NOT THAT I CAN THINK OF. P/ NO.

WE HAVE GROUP HEALTH ALREADY. C/ IT WORKS FOR US SO I WON'T CHANGE. P/
NO.

I DON'T WANT THE GOVERNMENT TO PAY FOR OUR HEALTH INSURANCE. WE PAY
ENOUGH NOW IN TAXES. DON'T NEED TO PAY ANY MORE. P/ IT IS LOUSY
INSURANCE. P/ THAT'S IT.

THEY ARE COVERED THROUGH MY HEALTH INSURANCE. I WOULD NOT NEED ANY
OTHER. P/ THAT IS IT.

NOT AS GOOD OF COVERAGE. THAT IS WHY I AM SOMEWHAT UNLIKELY.

WE HAVE HEALTH CARE INSURANCE THROUGH EMPLOYER

CURRENTLY ON A FREE INSURANCE PROGRAM. P/ WOULD NOT WANT TO CHANGE
TO ANOTHER PROGRAM THAT WE WOULD HAVE TO PAY FOR. IT WOULD HAVE TO
BE FREE ALSO. P/ NO.

WE ALREADY HAVE HEALTH INSURANCE THROUGH MY EX-HUSBAND'S EMPLOYER.
P/ I THINK THEY SHOULD OFFER IT TO SOMEONE ELSE WHO NEEDS IT. P/ NO.

THE STATE WILL RAISE MY TAXES. P/ NO.

I HAVE A UNION JOB THAT PROVIDES INSURANCE. P/ NO.

ALREADY HAVE INSURANCE THROUGH HUSBAND'S EMPLOYER. P/ NO.

I HAVE INSURANCE ON AN EIGHTEEN YEAR OLD ON MY POLICY THROUGH WORK FOR ONLY A FEW DOLLARS MORE A MONTH. AT THAT RATE, I DON'T SEE ANY REASON I SHOULD CHANGE. HE WILL ONLY BE ELIGIBLE FOR A SHORT WHILE LONGER ON MY POLICY.

WE HAVE INSURANCE THROUGH MY HUSBAND'S EMPLOYER. C/ IT IS AT A REASONABLE RATE THAT WE CAN AFFORD.

MY HUSBAND SERVES IN THE MILITARY. WE ARE ALL COVERED BY THE U.S. GOVERNMENT AT NO COST.

I DON'T FEEL THAT WE WOULD QUALIFY. P/ NO.

I HAVE HEARD OF MANY PROS AND CONS. I WOULD HAVE TO DO SOME RESEARCH BEFORE I MADE A DECISION. P/C: PREMIUMS GOING UP AND DOWN.

I DON'T THINK THAT WE ARE ELIGIBLE FOR IT.

WE ARE ALREADY COVERED.

THEY ARE ALREADY COVERED. P/ ON THE CHIP PROGRAM, I WOULD HAVE TO INVESTIGATE IT FIRST. P/ NO.

AT THE CURRENT TIME, OUR INSURANCE COVERS OUR CHILDREN FINE. P/ NOT PARTICULARLY. I MEAN WE WOULD PROBABLY LOOK INTO IT. UNLESS OUR CURRENT INSURANCE GAVE US A PROBLEM WE WOULD NOT SWITCH. P/ I DO NOT THINK SO.

THEY ARE STATE SPONSORED. THEY JUST GET YOU IN AND GET YOU OUT. THEY ARE NOT AS GOOD AS THE ONES YOU PAY FOR. THEY ARE HMOS. NOT AS GOOD AS ONES YOU PAY FOR, IN MY OPINION. WE HAD FRIENDS THAT WENT OVER. HAVE TO BE RECOMMENDED FOR CARE. IF YOU WANT A DOCTOR, YOU WANT TO BE TAKEN RIGHT THERE. P/ OUR INCOME IS TOO HIGH. P/ NO.

I HAVE NO NEED FOR IT, NOR DO I FORESEE A NEED FOR IT. BESIDES, I THINK THAT THERE ARE MORE PEOPLE OUT THERE THAT REALLY NEED THE HELP WORSE THAN US.

ALREADY COVERED FOR INSURANCE. P/ NO.

OUR CHILDREN ARE ALREADY COVERED THROUGH OUR EMPLOYERS. P/ NO.

THEY DON'T COVER AS MUCH AS PRIVATE INSURANCE. THEY ARE STRICT AT WHAT THEY PAY FOR. P/ NO.

ALREADY HAVE HEALTH INSURANCE.

ALREADY HAVE HEALTH INSURANCE.

FOR ONE, THE ADULT IN THE HOUSEHOLD WOULD BE APPLYING. P/ THE MINOR IS COVERED THROUGH THE EMPLOYER OF THE FATHER.

WE WOULDN'T QUALIFY.

WE HAVE ALWAYS GOTTEN IT THROUGH MY HUSBAND'S EMPLOYER. WE HAVE NOT BEEN ABLE TO GET STATE INSURANCE BECAUSE HE MAKES TOO MUCH MONEY.

THE AGENCIES ARE TRYING TO GET OUT OF DOING IT FOR THE STATE. THAT MAKES ME ANGRY.

AT THIS POINT, WE ARE COVERED THROUGH EMPLOYERS, WHICH IS THE RIGHT COVERAGE. I KNOW THAT A COUPLE OF THE KIDS WOULD IF THEY DID NOT WORK.

I DON'T BELIEVE THAT THERE ARE ANY WASHINGTON STATE PROGRAMS THAT WOULD COINCIDE WITH MY HUSBAND'S WORK INSURANCE.

WE DON'T KNOW ABOUT THE PROGRAM. WE DON'T KNOW IF WE CAN AFFORD IT.

I FEEL IN WASHINGTON STATE WE'RE ALREADY TAXED TOO MUCH. IF THERE ARE MORE STATE FUNDED PROGRAMS, IT MEANS THERE WILL BE MORE TAXES. P/ THE FACT I CAN GET IT THROUGH MY EMPLOYER. P/ NO.

MY DAUGHTER IS WORKING. HAS HER OWN HEALTH INSURANCE. P/ NO OTHER REASONS.

WE HAVE SUCH A GOOD INSURANCE POLICY WITH MY HUSBAND'S UNION.

I HAVE IT THROUGH MY EMPLOYER.

THEY ARE COVERED UNDER MY INSURANCE.

I REALLY LIKE THE PROGRAM WE HAVE. I WOULD HAVE TO BE CONVINCED THAT THE OTHER PROGRAM WAS BETTER. WE DON'T HAVE A PREMIUM. THE COVERAGE

IS EXCELLENT. IT WOULD BE AWFULLY DIFFICULT TO BEAT. WE CAN CHOOSE WHOEVER WE WANT TO GO TO.

I HAVE VERY GOOD HEALTH INSURANCE. P/ NO.

WE HAVE REALLY GOOD HEALTH INSURANCE COVERAGE THROUGH THE EMPLOYER. P/ NO.

HAVE INSURANCE THAT COVERS CHILDREN ON HUSBAND'S INSURANCE. P/ NO.

JUST WOULD NOT BE NEEDED. P/ WE HAVE INSURANCE ALREADY. P/ NO.

WE ARE ALREADY COVERED. P/ WE DON'T NEED ANY ADDITIONAL INSURANCE FROM WHAT WE ALREADY HAVE. P/ NO.

I AM VERY SATISFIED WITH MY INSURANCE THROUGH WORK. P/ I DON'T THINK WE WOULD QUALIFY.

I THINK FROM MY KNOWLEDGE STATE PROGRAMS SEEM TO COST MORE THEN THE PROVIDER I HAVE THROUGH WORK. P/ NO.

WE'RE ALREADY COVERED. THERE'S NO POINT IN CHARGING THE STATE AGAIN OR MYSELF, IF YOU LOOK AT IT THAT WAY. C/ AS A TAXPAYER. P/ NO.

THE INSURANCE WE HAVE TAKES CARE OF IT. IT'S SUFFICIENT TO COVER OUR NEEDS. P/ NOPE, I CAN'T THINK OF ANY.

MY EMPLOYER PAYS FOR MY INSURANCE. P/ NOPE.

WE ARE COVERED UNDER MY HUSBAND'S INSURANCE FORM WORK. P/ NO REASON TO APPLY FOR ANY OTHER PROGRAMS. P/ NO.

WE ALREADY HAVE BASIC HEALTH. P/ WE ARE NOT FAMILIAR WITH THE CHIP PROGRAM. P/ NO.

I DON'T KNOW.

I ALREADY HAVE INSURANCE. P/ I DOUBT THEY WOULD BE ABLE TO BEAT THE RATES OR THE QUALITY OF SERVICE. P/ NONE.

IF THEY CHARGED US FOR IT, WE CAN GET FREE COVERAGE FROM WASHINGTON STATE BASIC HEALTH PLAN. I WOULDN'T WANT TO PAY ANYTHING. P/ NO.

State of Washington
SCHIP Annual Report
January 31, 2001

WE ALREADY HAVE INSURANCE THROUGH EMPLOYER. IF THAT WAS LOST, STATE INSURANCE WOULD BE A LAST RESORT. I DON'T LIKE TO BE A BURDEN ON THE STATE.

THEY COST. C/ MY CHILDREN ALREADY HAVE FREE COVERAGE.

I HAVE NEVER HEARD OF IT. P/ NO, THAT'S IS IT. I JUST NEED SOME INFORMATION BEFORE I DO THINGS.

THEY ALREADY HAVE GOOD COVERAGE WHERE THEY'RE AT NOW. P/ NO.

I ALREADY HAVE INSURANCE. P/ THAT'S ABOUT IT.

WE ALREADY HAVE INSURANCE. P/ NO.

I DON'T THINK THAT WE WOULD QUALIFY.

WE ALREADY HAVE INSURANCE THROUGH OUR EMPLOYER. WE HAVE NO NEED FOR MORE INSURANCE THROUGH A DIFFERENT COMPANY.

MINE IS EXTREMELY GOOD INSURANCE. C/ FULLY COVERED. P/ NOTHING ELSE.

IT WOULD DEPEND ON THE COVERAGE. I DON'T THINK OUR COMBINED INCOME WOULD QUALIFY US. NOW OUR INCOME IS INCREASING.

MY INSURANCE IS PAID FOR BY MY EMPLOYER

THEY ALREADY HAVE INSURANCE THROUGH BASIC HEALTH

I HAVE INSURANCE THROUGH WORK.

SHE HAS INSURANCE THROUGH US AND THROUGH COLLEGE. P/ NO.

MY CHILDREN ALREADY HAVE COVERAGE RIGHT NOW.

MY CHILD IS 17, SO SHE WILL ONLY BE MY DEPENDENT FOR ANOTHER YEAR. C/ I WOULDN'T WANT TO MESS AROUND CHANGING THINGS AT THIS POINT. P/ I HAVE HER ON MY INSURANCE RIGHT NOW. C/ MY EMPLOYER PROVIDES THE INSURANCE.

RIGHT NOW, I'VE BEEN LAID OFF FROM WORK AND MY CHILD GETS FREE HEALTH

CARE THROUGH THE STATE. I WOULDN'T WANT TO CHANGE TO A HEALTH CARE PLAN FOR WHICH I WOULD HAVE TO PAY. P/ NO.

THEY ARE ALREADY COVERED ON MY INSURANCE. P/ NO.

Q.17 What programs or organizations are you aware of that help people apply for Washington State-sponsored health plans?

(Other responses)

TELEPHONE NUMBERS ON THE TV

HEAD START PROGRAM

VOCATIONAL REHAB. SOCIAL
SECURITY OFFICE

SOCIAL SERVICES

HEAD START

HEALTHY OPTIONS (2 MENTIONS)

CITY YEAR

UNEMPLOYMENT OFFICE (2
MENTIONS)

BLUE MOUNTAIN ACTION COUNCIL

HOME CARE. SENIOR INFORMATION
AGENCIES

STATE

FARM WORKERS CLINIC

BOEING HAS A PROGRAM THAT HELPS
PEOPLE

PUBLIC SCHOOL (2 MENTIONS)

WORKING SOLUTIONS THROUGH
EMPLOYER HELPS US GET
COMMUNITY SERVICE INFORMATION

DEPARTMENT DEVELOPMENTALLY
DISABLED.

DAY CARE CENTERS

HUD

DDD

EMPLOYERS

TACOMA BRANCH OF THE NATIONAL
URBAN LEAGUE INCORPORATED.
DIZMAN BOYS RANCH

D.8 May I ask the industry in which you are employed?

(Other responses)

PASTOR

D.9 How would you describe your ethnicity?

(Other responses)

MULTICULTURAL. C/ NO

MIXED RACE

AFGHANISTAN

Document 2



Healthy Kids Now! Marketing Campaign Plan

August 2000-July 2001

Goal:

The goal of the 2000-2001 Healthy Kids Now! marketing campaign is to build on the momentum established in phase one of the campaign, adjust tactics based on results and feedback received to date, and to increase client contacts by **15%** (greater than phase one contacts). Client contacts are defined as 1-877-KIDS-NOW hotline calls and direct calls to local outreach projects.

Strategies:

- *Enhance **media relations** efforts:* One of the most effective tactical areas in phase one, media relations, remains a high priority. We hope to have the Governor at targeted events as a media draw, but the campaign will utilize a strong media relations effort either way.
- *Continue statewide **multi-media campaign**:* This includes fine-tuning all of the current elements in use, as well as testing new methods (i.e. direct mail) to achieve as much broad coverage as possible.
- *Work closely with **key stakeholders**:* Use of such resources as the Governor's office, advisory committees, outreach workers, and volunteers is important to determine and measure effectiveness of the campaign.
- *Continue to work with appropriate **state departments**:* This element is a helpful tool for measuring progress to date and evaluating what the best collateral materials are to use for carrying out the campaign objectives.

Important Lessons Learned:

The final phase one report will more thoroughly overview results of the campaign. Some of the key marketing campaign learnings were:

- **TV** generated the most calls to the hotline BY FAR
- Media relations, especially creating feature stories with local news outlets, was the second place tactic
- The **collateral pieces** were very popular with local outreach projects. After an initial printing of 140,000, an additional 500,000 rack cards were printed, based on demand.
- **Front-line feedback** from outreach projects advocates and partners was invaluable in making

campaign adjustments and in planning tactics.

- **Translations** were time-consuming and require more time and planning than was allotted in phase one.

2000-2001 Tactics:

PSA Campaign

The largest portion of the marketing campaign budget will again be allocated to the Statewide multi-media PSA campaign. Based on results from phase one, we recommend an increased emphasis on TV. TV generated the greatest number of calls to the hotline—more than double the volume of the next most effective tactic, which was newspaper coverage. The same gross rating point formula will be utilized to ensure equal “coverage” in each market. However, in the Washington TV markets, no radio will be purchased and those dollars will be redirected to TV. In Southwestern Washington and in Klickitat County, where TV is not available a combination of billboards, direct mail, radio and print will likely be utilized to achieve GRP’s.

The timing of the flights will again be staggered and will occur in Jan-March of 2001 (fall of 2000 is not feasible because of elections and the resulting inflated TV pricing and limited availability). Spot-for-spot matches will again be sought for all paid spots.

Consumer focus groups will be used to test existing PSA spots (as well as new concepts) and will help to determine which spots are used in the January-March buy.

Coordination with Local Outreach Projects

The link with local projects is critical to the success of the campaign. To enhance this relationship and build on what was started in phase one, we recommend the following activities:

- Periodic newsletter to update outreach projects on campaign news and highlight tips/techniques that projects are finding successful
- Repeat survey to measure success and identify issues
- Increase local event coordination – local projects can access travel display, t-shirts, collateral and stickers for events in their communities
- Website will contain helpful information, including the new statewide update of the enrollment field guide and an accompanying training video.
- Collateral distribution tips and media relations tips and tools
- Send copies of PSA’s to all local outreach projects

Collateral

Printed materials will mirror phase one materials. The posters, rack cards and brochure/application will be reprinted as needed. The brochure/application piece (now in its pilot phase) will be finalized and reprinted with a January target date. It will be translated into 7 languages. All Medicaid outreach projects, advocacy groups, health districts and other interested organizations will be able to continue to order materials directly

from the DSHS warehouse.

Rack card holders will be ordered in phase two and distributed to outreach projects and other venues (pharmacies, etc.) to effectively display rack cards on counter tops and in lobbies.

Stickers will also be ordered to give out at community events and in other venues. The stickers will have the HKN! logo and phone number.

New distribution tactics include:

NOTE: collateral distribution is done primarily through local outreach projects. These distribution tactics will be coordinated closely with projects. Many counties are already distributing in some of these channels. A few counties are not currently served by a local outreach project. The HKN! campaign's goal will be to fill gaps where they exist and assist local outreach projects to expand their reach. The campaign will not duplicate efforts already underway in local communities. It will also seek to establish partnerships with large businesses and associations which the local projects could then leverage in their communities.

- An effort to put **a rack card in the backpack of every child** attending school in our target age group (0-19) through partnerships with school districts, private schools and OSPI.
- Direct mailing to populations that are hard to reach via **Val-Pak**(a direct mail coupon type package). We will pick **rural counties with high uninsured rates** to target and test this direct mail strategy. **Asotin, Klickitat and Wahkiakum counties** do not have local Medicaid outreach projects.
- A mailing to **child care centers** to encourage distribution to parents.
- Increased collaboration with **hospitals** to encourage displays and posting of information in venues such as waiting rooms, ER, elevators.
- Increased collaboration with **Health Districts** to encourage displays and distribution in waiting rooms and other high traffic venues.
- Increased collaboration with targeted **employers** and HR departments to encourage communication with uninsured, part-time and contract employees.
- Increased collaboration with **physician offices and clinics** to distribute collateral.

Media relations

The second most effective marketing tactic in phase one was media relations. Phase two will seek to capitalize on statewide media relations opportunities through the use of events, news releases, human interest stories, national story tie-ins, and other tactics as appropriate. Morning news shows will be considered for a statewide media tour. Local outreach organizations will again be provided with information to conduct their own, local media relations efforts if desired.

Special Audiences

Special audience outreach will focus on enhancing tactics tailored for HKN! target special audiences—Hispanic/Latino, Native American and rural populations. These audiences are extremely important to the campaign because they are under-served (over double the state average for uninsured), frequently overlooked, and difficult to reach and create trust. Tactics for them take a lot of footwork and time spent in the communities in order to build relationships with leaders and get them behind the program. We want to

State of Washington
SCHIP Annual Report
January 31, 2001

build on what we learned in phase one.

- **Hispanic/Latino**- Tactics for reaching the Hispanic/Latino population include: Spanish radio and print ads, getting to the information givers, identify and attend special events, work with businesses in community on national and local levels so the message gets out to community as both consumers and employees.
- **Native American**- Many of the same tactics as Latino population. Work with tribal leaders. Differentiate program as needed.
- **Rural** – We will focus on collateral distribution and media relations tactics in rural communities. Special emphasis will be placed on counties without local outreach projects: Asotin, Klickitat and Wahkiakum.

Special Events

Special events give HKN! a face-to-face opportunity with families. Events can be used to distribute information, answer questions, and even assist with filling out applications. Partnering with local outreach projects to attending targeted events, such as fairs, kids events and holiday events (that are most likely to draw families) can be a relatively inexpensive ways to sign up large numbers of eligible applicants. The early fall (September), holiday season (November-December) and late spring (May- June) are likely the best times for special events around the State.

Governor Locke's Participation—We will keep coordinating with Governor Locke's office and will attempt to leverage his potential involvement or appearance at any special events statewide.

Research

Phase two research will focus on evaluation of the marketing campaign and the call response functions. Outcome research will focus on a sample of hotline callers and will follow them through their call for help and the resulting outcomes. Focus groups with consumers will test all PSA creative as well as some new concepts. This research will be used to make decisions on what to run for the PSA campaign starting in January. In conjunction with the regular advisory committee feedback, these tactics will constantly inform the campaign with the latest results.

Phase Two Timeline – September 2000 to June 2001

TACTIC	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	Jun
PSA campaign					→		→			
Outreach project coord	→									→
Collateral	→									→
Media Relations	→	→			→					
Spec Audiences					→					
Spec Events	→	→		→					→	→

State of Washington
SCHIP Annual Report
January 31, 2001

Research			→							
----------	--	--	---	--	--	--	--	--	--	--

SECTION 2. AREAS OF SPECIAL INTEREST

This section has been designed to allow you to address topics of current interest to stakeholders, including; states, federal officials, and child advocates.

2.1 Family coverage:

1. If your State offers family coverage, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other program(s). Include in the narrative information about eligibility, enrollment and redetermination, cost sharing and crowd-out.

The state of Washington does not offer family coverage through Title XXI. A demonstration concept paper was submitted to HCFA on October 14, 2000, proposing a SCHIP expansion for family coverage. Please see Attachment 1.

2. How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2000 (10/1/99 -9/30/00)?

Number of adults: NA

Number of children: NA

3. How do you monitor cost-effectiveness of family coverage?

Not applicable

2.2 Employer-sponsored insurance buy-in:

1. If your State has a buy-in program, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP program(s).

The state of Washington does not offer Employer-sponsored insurance buy-in.

2. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2000?

Number of adults _____

Number of children _____

Not applicable

State of Washington
SCHIP Annual Report
January 31, 2001

2.3 Crowd-out:

1. How do you define crowd-out in your SCHIP program?

There are two general types of individual crowd-out. A family with employer-sponsored coverage or other private coverage could elect to drop that coverage and enroll in a publicly subsidized program. Crowd-out also could occur over time as previously uninsured families who enrolled in public programs elect to remain in those programs when offered employer-sponsored coverage.

In addition to individual crowd-out, there could be crowd-out effects by employers or the private market. Employers with a substantial share of low-wage workers could decide, through bargaining with their workers, to pay their employees higher cash wages instead of having dependent health insurance as part of the compensation package. In this case, the employee saves not only his direct premium payment for dependent coverage, but also receives higher cash wages.

2. How do you monitor and measure whether crowd-out is occurring?

To monitor for crowd out, staff will contact all applicants' households reporting insurance coverage within the past four months to determine why the applicant did not have insurance coverage at the time of SCHIP application. We will develop a telephone survey instrument in coordination with HCFA to ensure that both agencies' concerns about why applicants no longer have coverage are addressed. The interview findings will be reported on a semi-annual basis to HCFA, the Governor, and State Legislative Committees.

If it is found that 10% or more of the SCHIP enrollees had other insurance coverage prior to SCHIP enrollment and elected to drop that coverage in order to enroll in SCHIP, we will develop other strategies to reduce crowd out. These may include waiting periods, increased premium payment requirements, and/or other methods. We will submit these strategies to HCFA for review prior to taking necessary legislative or rule making action.

Although Washington has not adopted waiting periods for SCHIP, the program has cost-sharing requirements that discourage crowd out. Families are required to pay a \$10 per child monthly premium, with a \$30 family maximum. In addition, the family is required to make co-payments for physician, certain drug prescriptions and emergency room usage. On average, the family will incur \$25 per month per child in cost-sharing requirements.

3. What have been the results of your analyses? Please summarize and attach any available reports or other documentation.

State of Washington
SCHIP Annual Report
January 31, 2001

We are collecting data but no meaningful analysis has been made to date. We anticipate this can be done for the next annual report.

4. Which anti-crowd-out policies have been most effective in discouraging the substitution of public coverage for private coverage in your SCHIP program? Describe the data source and method used to derive this information.

Since Washington's SCHIP began in February of this year, we have not yet conducted data analyses to determine which of our policies are most effective in discouraging crowd-out.

2.4 Outreach:

1. **What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?**

We have set into place a combination of activities that include a statewide public information campaign and local outreach. The public information campaign works very closely with existing outreach contractors to support their efforts and ensure marketing and materials augment their efforts rather than presenting conflicting messages or stepping over activities already in place. The link with local outreach efforts has been critical to the success of the campaign.

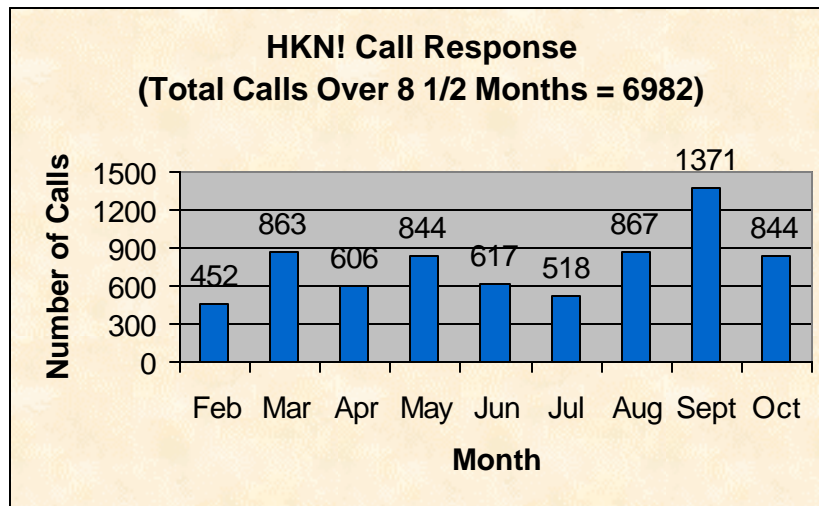
Healthy Kids Now! Public Information Campaign. SCHIP was launched on February 17, 2000, along with a statewide public awareness campaign, Healthy Kids Now! (HKN!), aimed at families with children potentially eligible for any one of the State's children's programs. To direct activities, we contracted with an already very successful community outreach group, Health Improvement Partnership, located in Spokane. A statewide advisory group was formed with interested stakeholders from state, local, tribal, and advocacy groups to ensure the state and its diverse voices were represented and participated in all decision making.

To inform this group and set a solid foundation, a national best practices search, a quantitative survey, demographic research on target audience, and key informant interviews were completed. From this information a media campaign and collateral material, including a rack card (See Attachment 2), rack card holder, poster, and brochure/application (See Attachment 3), were developed. Print materials were translated into seven languages.

We established as the campaign's call to action the national number, 1-877-Kids Now, and set up the line with a seasoned and highly knowledgeable stakeholder, Healthy Mothers, Healthy Babies (HMHB). Professional call center staff are familiar with Medicaid, screen callers for eligibility, answer questions, help applicants fill out applications, and refer the caller to outreach projects for a local

State of Washington
SCHIP Annual Report
January 31, 2001

connection. This center took well over 6,900 calls during the reporting period. The following chart shows the total number of calls by month, beginning February 2000.



A staggered statewide multi-media campaign with PSAs, radio, print ads, and billboards which began in March and continued, off and on, through June. For the most part, these were spot for spot matches.

The simple, one-page (front and back) brochure/application, designed for all children's programs, was usability tested in Seattle, Spokane, and Yakima with potential clients, and was very favorably received.

It was also tested with state eligibility staff to ensure the questions are clear and elicit the needed information to reduce delays in eligibility determinations. The final application will be printed in January 2001.

The HKN! campaign has worked closely with key stakeholders, most noteworthy is the Governor's office. The Governor launched the State's SCHIP in February, filmed a PSA for HKN! in June, and participated in a September enrollment drive in four diverse Washington communities: Seattle, Spokane, Yakima, and Vancouver.

Outreach Activities

The following information on outreach activities is based on what has been used for Medicaid outreach.

Since children must be assessed for Medicaid eligibility, as a condition of determining SCHIP eligibility, SCHIP outreach has been blended into these efforts.

Background

In 1998, the Washington State Legislature authorized Medical Assistance Administration (MAA) to spend up to \$3.9 million in enhanced federal matching funds for outreach to Medicaid eligibles. The

State of Washington
SCHIP Annual Report
January 31, 2001

project started in October 1998.

Contracts

The state of Washington has contracted with 31 community-based organizations covering 33 out of the state's 39 counties. Contractors include health districts, county social service departments and eight Indian tribes. We required contractors to submit applications that had to be approved before proceeding. After signing contracts, we provided local training to project staff on outreach strategies, eligibility criteria, and enrollment process. The State is reimbursing contractors by paying a monthly set rate and paying a \$20 incentive for each client a contractor helps enroll. The community contracts were scheduled to end March 31, 2000 when the authorizing federal legislation sunsetted. In November 1999, however, Congress lifted the sunset date, so we will be able to extend the outreach contracts to June 30, 2001, or until the enhanced federal funds are spent.

Contractors are required to:

- Identify people likely to be eligible for Medicaid coverage;
 - Educate potential eligibles on the benefits of participating in the Medicaid program and eligibility requirements;
 - Assist potential eligibles to complete application for Medicaid eligibility;
 - Educate new Medicaid recipients on how to access services; and
 - Assist new Medicaid recipients to select a Healthy Options health care plan that will best meet their needs.
2. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?

We addressed two special audiences in our media campaign: Hispanic/Latino and American Indian/Alaska Native (AI/AN). We ran Spanish print and radio ads and distributed materials to 22 clinics and other Hispanic organizations. For AI/AN we placed ads in tribal publications, sent mailings to all Washington tribes, and distributed collateral to 18 tribal clinics. Our rack cards and posters are printed in seven languages, including Spanish, Vietnamese, Russian, Chinese, Korean, and Cambodian. The application is in pilot form and was printed in English and Spanish only. In its final form, it will be printed in seven languages and others as the need arises.

3. Which methods best reached which populations? How have you measured effectiveness?

Television generated the most calls to the HKN! toll-free number, 1-877-KIDS-NOW. Media relations, especially creating feature stories with local news outlets, was the second best tactic. The rack card and poster were very popular with local outreach projects. After an initial printing of 140,000, an additional 500,000 rack cards were printed on demand. Front-line feedback from

State of Washington
SCHIP Annual Report
January 31, 2001

outreach projects, advocates, and partners was invaluable in making campaign adjustments and in planning tactics throughout the period of this report.

To summarize, contractors use a variety of strategies to maximize outreach efforts statewide, including:

- Multimedia marketing with massive information dissemination;
- Collaboration with various community partners/advocates;
- Training partners in screening for children's medical applications; and
- Application sites at various locations in communities statewide.

2.5 Retention:

1. What steps are your State taking to ensure that eligible children stay enrolled in Medicaid and SCHIP?

Once enrolled, a child remains eligible for twelve consecutive months regardless of income changes. At the tenth month of enrollment, the client is asked to fill out an eligibility review so that eligibility can be determined before the twelve month period expires. There have been no redeterminations completed on SCHIP families as of this report's date since SCHIP began February 2000. We will continue to develop strategies to ensure that children stay enrolled in Medicaid and SCHIP.

2. What special measures are being taken to reenroll children in SCHIP who disenroll, but are still eligible?

This issue will be addressed in 2001.

- ___ Follow-up by caseworkers/outreach workers
- ___ Renewal reminder notices to all families
- ___ Targeted mailing to selected populations, specify population _____
- ___ Information campaigns
- ___ Simplification of re-enrollment process, please describe _____
- ___ Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe _____
- ___ Other, please explain _____

3. Are the same measures being used in Medicaid as well? If not, please describe the differences.

This issue will be addressed in 2001.

4. Which measures have you found to be most effective at ensuring that eligible children stay enrolled?

State of Washington
SCHIP Annual Report
January 31, 2001

Since Washington's SCHIP began in February of this year, we have not yet conducted data analyses to determine which of our measures are most effective in ensuring that eligible children stay enrolled.

5. What do you know about insurance coverage of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured?) Describe the data source and method used to derive this information.

We are collecting data but no meaningful analysis has been made to date. We anticipate this can be done for the next annual report.

2.6 Coordination between SCHIP and Medicaid:

1. Do you use common application and redetermination procedures (e.g., the same verification and interview requirements) for Medicaid and SCHIP? Please explain.

As part of the process to determine SCHIP eligibility, information must be collected that is not needed to determine eligibility for other medical programs. For example, as part of the SCHIP eligibility process, families must:

- Indicate whether a child has creditable insurance at the time of application,
- Indicate whether they dropped employer-sponsored dependent coverage within 4 months of making a SCHIP application,

As a way to collect this information, we added a step to the SCHIP eligibility determination process. This additional step is taken after it is determined that the family income is too high for Medicaid, but is within the limits for SCHIP. This step consists of sending the family a separate mailing. If the family does not return the required information, they are not SCHIP eligible.

Client advocates and others have told us that this second step is confusing. As a result of this feedback, we are exploring ways to eliminate or reduce the complexity of this second step.

The state of Washington will use two standardized application forms to make eligibility determinations. One form is used for clients applying for the Medicaid children's medical program (a one-page form). The other form is used for clients applying for cash benefits, food stamps, medical coverage and other benefits. Potential SCHIP eligibles can apply for medical coverage by using either form. Both forms will be processed centrally through our Medical Eligibility Determination Services (MEDS) section or by the local Community Service Offices (CSOs).

Information from the application will be entered into the state's ACES, which will automatically generate SCHIP eligibility notices and yearly reviews. ACES will transfer eligibility information to the Medicaid Management Information System (MMIS). MMIS information will be used to enroll clients into

managed care.

2. Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes.

If a child becomes eligible for Medicaid due to a decrease in income, staff enter the income change in the Automated Client Eligibility System (ACES) and the case automatically and immediately, based on ACES deadline dates, changes to Medicaid. The change in ACES then triggers a letter that is sent to the client informing the client of the change. This process can occur at anytime during the twelve month SCHIP certification period.

If a family's income increases above 200% of FPL, the case is pended and an enrollment packet and questionnaire are sent to the household. Once the packet and questionnaire are returned, staff review the information to determine eligibility. If eligible, the client is enrolled into the SCHIP.

3. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

Washington's SCHIP will utilize Washington's Medicaid managed care delivery system wherever practicable. This managed care system consists of contracts with health carriers for medical care coverage, contracts with Regional Support Networks for mental health care, and fee-for-service (FFS) for primary care case management (PCCM) clinics. Other Medicaid services are "carved out" of managed care and provided on a "wrap around" FFS basis. These include dental coverage, chemical dependency services, eyeglasses, hearing aid devices, abortions, and non-emergent transportation.

Availability of practitioners

MCOs must have a written access plan describing the mechanisms used to assure the availability of primary care providers (PCPs) and physician specialists, hospitals, and pharmacies. Standards for the number and geographic distribution of PCPs and specialty care practitioners are established in the procurement requirements. Like the regular Medicaid HO procurement, MAA will request MCOs to submit their provider networks. MCOs must collect and analyze data to measure performance against these standards and implement corrective action when necessary.

As part of the procurement process, HO bidders are required to submit GeoNetwork analysis that describes how its network compares to MAA/HCA access guidelines for distribution (travel distance) and capacity of primary care providers (PCPs), obstetrical providers, hospitals and pharmacies. This information is compared to BHP and Public Employee Benefit Board (PEBB) networks to judge whether there is sufficient capacity. HO, BHP and PEBB plans are required to submit monthly updates of provider network changes. MAA and HCA are implementing a new Integrated Provider Network Data Base (IPND) which will allow the two agencies to conduct ongoing GeoNetwork analysis to

ensure that there continues to be an adequate network during the contract period, and to assess whether there is a significant turnover of participating providers. We will apply this same analysis to its SCHIP plans.

2.7 Cost Sharing:

1. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

We have not yet developed a means of assessing the effects of premiums/enrollment fees on participation in SCHIP. We anticipate the development and employment of an assessment sometime in the spring of 2001.

2. Has your State undertaken any assessment of the effects of cost-sharing on utilization of health service under SCHIP? If so, what have you found?

We have not yet developed a means of assessing the effects of cost-sharing on utilization of health service under SCHIP. We anticipate the development and employment of an assessment sometime in the spring of 2001.

2.8 Assessment and Monitoring of Quality of Care:

1. What information is currently available on the quality of care received by SCHIP enrollees? Please summarize results.

The assessment of SCHIP enrollees' satisfaction with their health care and services will be based on our work with the Consumer Assessment of Health Plans (CAHPS). We have conducted two CAHPS surveys to date. These surveys were conducted in accordance with CAHPS Consortium (a group of national survey experts associated with the Harvard Medical School, RAND, and the Research Triangle Institute) protocols. The 1997 survey measures clients' satisfaction with the health care and services received through the Medicaid Healthy Options (HO) program. The 1998 survey included both HO enrollees and Medicaid FFS clients. To the extent possible, a similar survey approach will be used to assess SCHIP enrollees' satisfaction with care.

We will have information from a Consumer Assessment of Health Plans Survey and EPSDT analysis by winter 2002. The analysis will be conducted by an external quality review organization.

2. What processes are you using to monitor and assess quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, immunizations, mental health, substance abuse counseling and treatment and dental and vision care?

The quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and age appropriate immunizations provided under the plan, will be addressed for managed care coverage through contract requirements for participating Managed Care Organizations (MCOs). Requirements and monitoring criteria will be the same as those for the current HO and the fee-for-

service (FFS) programs.

The State will contract only with MCOs that are regulated by the Office of the Insurance Commissioner (OIC), which regulates and monitors financial solvency and other consumer protection safeguards.

MAA will monitor the quality and appropriateness of care through:

- Monitoring and analysis of quality standards and performance measures for well-baby care, well-child care, and immunizations required through encounter data, chart review, HEDIS reporting, and a variety of other contract monitoring activities listed below;
- Client interviews;
- Annual client satisfaction/health status surveys for both managed care and FFS clients;
- Complaint management system;
- Exemption/disenrollment/fair hearing database;
- Standards for health plan internal quality improvement programs;
- Network adequacy standards; and,
- On-site contract compliance monitoring and technical assistance.

Contract monitoring will be performed through the following actions:

Requiring the same encounter data reporting (form, format, periodicity) as required under the current HO program;

Generating of HEDIS reporting and the above mentioned quality measures with the same criteria as the HO program and similar FFS review;

- Applying utilization controls for FFS coverage that are consistent with all current utilization review requirements under the state's Medicaid plan. Examples of controls include external review of hospital claims data, exception-to-policy procedures, data audits, pre-authorization for extended coverage utilization, and drug utilization review;
- Performing routine on-site quality and operational reviews of the MCO contractors;
- Reviewing of the MCOs by an External Quality Review Organization (EQRO), as required by

federal law (Section 1902 (a) (30) (C) of the Social Security Act);

- Requiring that MCOs maintain an internal program of quality assurance, as required by federal regulations (42 CFR 434.34);
 - Performing annual client satisfaction surveys;
 - Monitoring of complaints and grievances at both the health plan level and the Medicaid State agency level.
3. What plans does your SCHIP program have for future monitoring/assessment of quality of care received by SCHIP enrollees? When will data be available?

We have been utilizing HEDIS and EPSDT related measures to assess the effectiveness of its HO contractors to provide medically appropriate services to Medicaid clients since 1996. Similar measures are now being applied to Medicaid FFS clients. MAA will contract with its external review organization to generate a set of similar, child appropriate measures for SCHIP enrollees. Since HEDIS and EPSDT analyses can not be completed without one calendar year's continuous enrollment, and given SCHIP began February 2000, we will collect the 2001 data and report our findings in 2002. HEDIS measures will be available in June 2002; EPSDT will be available in December 2002.

SECTION 3. SUCCESSES AND BARRIERS

This section has been designed to allow you to report on successes in program design, planning, and implementation of your State plan, to identify barriers to program development and implementation, and to describe your approach to overcoming these barriers.

3.1 Please highlight successes and barriers you encountered during FFY 2000 in the following areas. Please report the approaches used to overcome barriers. Be as detailed and specific as possible.

Note: If there is nothing to highlight as a success or barrier, Please enter NA=for not applicable.

- | | |
|-------------------------------------|--|
| 1. Eligibility | NA |
| 2. Outreach | NA |
| 3. Enrollment | Nearly 20% of the projected total eligible SCHIP population has been enrolled within the first eight months of the program. This success can be attributed to a “user-friendly” application and aggressive outreach efforts. |
| 4. Retention/disenrollment | NA |
| 5. Benefit structure | NA |
| 6. Cost-sharing | NA |
| 7. Delivery systems | NA |
| 8. Coordination with other programs | NA |
| 9. Crowd-out | NA |
| 10. Other | NA |

SECTION 4. PROGRAM FINANCING

This section has been designed to collect program costs and anticipated expenditures.

4.1 Please complete Table 4.1 to provide your budget for FFY 2000, your current fiscal year budget, and FFY 2002 projected budget. Please describe in narrative any details of your planned use of funds.

Note: Federal Fiscal Year 2000 starts 10/1/99 and ends 9/30/00).

	Federal Fiscal Year 2000 costs	Federal Fiscal Year 2001	Federal Fiscal Year 2002
Benefit Costs			
Insurance payments			
Managed care	811,959	4,189,090	6,478,007
per member/per month rate X # of eligibles			
Fee for Service	759,246	3,554,299	5,236,238
Total Benefit Costs	1,571,205	7,743,389	11,714,245
(Offsetting beneficiary cost sharing payments)			
Net Benefit Costs	1,571,205	7,743,389	11,714,245
Administration Costs			
Personnel			
General administration	9,085	0	0
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/marketing costs	54,191	0	0
Other			
Total Administration Costs	63,276	774,339	1,171,425
10% Administrative Cost Ceiling	6,328	774,339	1,171,425
Federal Share (multiplied by enhanced FMAP rate)	1,041,395	5,071,130	7,636,025
State Share	529,810	2,672,236	4,064,901
TOTAL PROGRAM COSTS	1,640,809	9,292,067	14,057,095

4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2000.

The state of Washington does not offer family coverage through Title XXI.

4.3 What were the non-Federal sources of funds spent on your CHIP program during FFY 2000?

- ☒ State appropriations
- ☐ County/local funds
- ☐ Employer contributions
- ☐ Foundation grants
- ☐ Private donations (such as United Way, sponsorship)
- ☐ Other (specify) _____

A. Do you anticipate any changes in the sources of the non-Federal share of plan expenditures.

We do not anticipate any changes at this time.

SECTION 5: SCHIP PROGRAM AT-A-GLANCE

This section has been designed to give the reader of your annual report some context and a quick glimpse of your SCHIP program.

5.1 To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. If you do not have a particular policy in-place and would like to comment why, please do. (Please report on initial application process/rules)

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Program Name	Not Applicable	Children's Health Insurance Program (SCHIP)
Provides presumptive eligibility for children	<input type="checkbox"/> No <input type="checkbox"/> Yes, for whom and how long?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, for whom and how long?
Provides retroactive eligibility	<input type="checkbox"/> No <input type="checkbox"/> Yes, for whom and how long?	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, for whom and how long? Children are eligible back to the first of the month in which the application was received. For example, if we receive an application in May and eligibility is determined in June, we will cover care on a fee-for-service basis back to May 1. SCHIP does not follow the Medicaid rules that allows 3-months of retro-eligibility
Makes eligibility determination	<input type="checkbox"/> State Medicaid eligibility staff <input type="checkbox"/> Contractor <input type="checkbox"/> Community-based organizations <input type="checkbox"/> Insurance agents <input type="checkbox"/> MCO staff <input type="checkbox"/> Other (specify) _____	<input checked="" type="checkbox"/> State Medicaid eligibility staff <input type="checkbox"/> Contractor <input type="checkbox"/> Community-based organizations <input type="checkbox"/> Insurance agents <input type="checkbox"/> MCO staff <input type="checkbox"/> Other (specify) _____
Average length of stay on program	Specify months _____	Specify months <u>NA</u>
Has joint application for	<input type="checkbox"/> No	<input type="checkbox"/> No

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Medicaid and SCHIP	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> Yes
Has a mail-in application	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
Can apply for program over phone	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
Can apply for program over internet	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
Requires face-to-face interview during initial application	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
Requires child to be uninsured for a minimum amount of time prior to enrollment	<input type="checkbox"/> No <input type="checkbox"/> Yes, specify number of months _____ What exemptions do you provide?	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, specify number of months <u>4 months</u> (Employer-sponsored creditable coverage) What exemptions do you provide? <ol style="list-style-type: none"> 1. Parent lost job that covered children. 2. Parent with insurance died. 3. Child has a medical condition, that, without treatment, would be life-threatening or cause serious disability or loss of unction. 4. Employer ended job-related dependent coverage 5. Dependent coverage terminated because the client reached the maximum lifetime coverage amount. 6. Coverage under a COBRA extension period expired. 7. Dependent coverage was not reasonable available (e.g., client has to travel to another city or state to get care for children). 8. Domestic violence led to the loss of this coverage. 9. The family's total out-of-pocket maximum for employer sponsored dependent coverage is fifty dollars per month or more

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Provides period of continuous coverage <u>regardless of income changes</u>	<p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes, specify number of months _____ Explain circumstances when a child would lose eligibility during the time period</p>	<p><input type="checkbox"/> No</p> <p><input checked="" type="checkbox"/> Yes, specify number of months <u>12 months</u></p> <p>Explain circumstances when a child would lose eligibility during the time period</p> <ul style="list-style-type: none"> • The family fails to pay SCHIP premiums for 4 consecutive months; • A SCHIP child becomes Medicaid eligible (e.g., change in family income or family size, or SCHIP child becomes pregnant); or • A child reaches their 19th birthday during the 12 month eligibility period.
Imposes premiums or enrollment fees	<p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes, how much? _____</p> <p>Who Can Pay?</p> <p><input type="checkbox"/> Employer</p> <p><input type="checkbox"/> Family</p> <p><input type="checkbox"/> Absent parent</p> <p><input type="checkbox"/> Private donations/sponsorship</p> <p><input type="checkbox"/> Other (specify) _____</p>	<p><input type="checkbox"/> No</p> <p><input checked="" type="checkbox"/> Yes, how much?</p> <ul style="list-style-type: none"> • \$10 per child-per month, with a family maximum of \$30 per; families with 4 or more children pay a maximum of \$30 per month for SCHIP premiums. • American Indian/Alaska Native (AI/AN) are excluded from cost sharing. <p>Who Can Pay?</p> <p><input type="checkbox"/> Employer</p> <p><input checked="" type="checkbox"/> Family</p> <p><input checked="" type="checkbox"/> Absent parent</p> <p><input type="checkbox"/> Private donations/sponsorship</p> <p><input type="checkbox"/> Other (specify) _____</p> <p>Premium statements are sent to the head of household. We have no sponsorship programs established at this time.</p>
Imposes copayments or coinsurance	<p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p>	<p><input type="checkbox"/> No</p> <p><input checked="" type="checkbox"/> Yes</p>

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Provides preprinted redetermination process	<p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes, we send out form to family with their information precompleted and:</p> <p style="padding-left: 40px;"><input type="checkbox"/> ask for a signed confirmation that information is still correct</p> <p style="padding-left: 40px;"><input type="checkbox"/> do not request response unless income or other circumstances have changed</p>	<p><input checked="" type="checkbox"/> No</p> <p><input type="checkbox"/> Yes, we send out form to family with their information and:</p> <p style="padding-left: 40px;"><input type="checkbox"/> ask for a signed confirmation that information is still correct</p> <p style="padding-left: 40px;"><input type="checkbox"/> do not request response unless income or other circumstances have changed</p>

5.2 Please explain how the redetermination process differs from the initial application process.

The redetermination process does not differ from the initial application process

.

SECTION 6: INCOME ELIGIBILITY

This section is designed to capture income eligibility information for your SCHIP program.

6.1 As of September 30, 2000, what was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately. Please report the threshold after application of income disregards.

Title XIX Child Poverty-related Groups or Section 1931-whichever category is higher	Up to 200% of FPL for children under age 19.
Medicaid SCHIP Expansion	NA
State-Designed SCHIP Program	Over 200% but less than 250% of FPL for children aged 0 up to age 19.

6.2 As of September 30, 2000, what types and *amounts* of disregards and deductions does each program use to arrive at total countable income? *Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter **ANA**.*@

Do rules differ for applicants and recipients (or between initial enrollment and redetermination) ____ Yes **X** No
 If yes, please report rules for applicants (initial enrollment).

Table 6.2			
	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	State-designed SCHIP Program
Earnings	\$90	NA	\$90
Self-employment expenses	Actual business expenses	NA	Actual business expenses
Alimony payments Received	Actual amount	NA	Actual amount
Paid	Court ordered amount	NA	Court ordered amount
Child support payments Received	Actual amount	NA	Actual amount
Paid	Court ordered amount	NA	Court ordered amount
Child care expenses	Actual amount	NA	Actual amount
Medical care expenses	NA	NA	NA
Gifts (per Washington Administrative Code 388-450-0065)	Up to \$30 is disregarded	NA	Up to \$30 is disregarded
Other types of disregards/deductions (specify)	NA	NA	NA

6.3 For each program, do you use an asset test?

Title XIX Poverty-related Groups	<input type="checkbox"/> No	<input type="checkbox"/> Yes, specify countable or allowable level of asset test_____
Medicaid SCHIP Expansion program	<input type="checkbox"/> No	<input type="checkbox"/> Yes, specify countable or allowable level of asset test_____
State-Designed SCHIP program	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes, specify countable or allowable level of asset test_____
Other SCHIP program_____	<input type="checkbox"/> No	<input type="checkbox"/> Yes, specify countable or allowable level of asset test_____

6.4 Have any of the eligibility rules changed since September 30, 2000? ☐ Yes ☒ No

SECTION 7: FUTURE PROGRAM CHANGES

This section has been designed to allow you to share recent or anticipated changes in your SCHIP program.

7.1 What changes have you made or are planning to make in your SCHIP program during FFY 2001(10/1/00 through 9/30/01)? Please comment on why the changes are planned.

A. Family coverage

The state of Washington does not offer family coverage. A SCHIP Demonstration Proposal Concept Paper was submitted on October 13, 2000, to HCFA. The proposal expands health coverage to parents in SCHIP families (See attachment 1.)

B. Employer sponsored insurance buy-in

NA

C. 1115 waiver

Please see Family coverage above.

D. Eligibility including presumptive and continuous eligibility

The state of Washington will submit a State Plan Amendment to make eligibility requirements similar to the eligibility processes of the Washington State Medicaid program. No longer must an applicant choose a health plan or attest through signature that they will pay premiums to be found eligible. SCHIP applicants need only meet income and insurance requirements. This amendment will help in our efforts to bring about more efficiency and consistency between the two programs so that transition between the two programs is more transparent to clients and providers.

E. Outreach

No significant changes are planned at this time.

F. Enrollment/redetermination process

No changes are planned at this time.

G. Contracting

No changes are planned at this time.

H. Other

The state of Washington will submit a State Plan Amendment to allow for the assignment of eligible children into SCHIP managed care health plans. Once eligible, if applicants do not choose a health plan within 30 days in one of the five mandatory counties (a county with two or more managed care plans is considered a mandatory

State of Washington
SCHIP Annual Report
January 31, 2001

enrollment county), we will choose a plan for them.

Attachment 1

**STATE OF WASHINGTON
SCHIP DEMONSTRATION PROPOSAL
CONCEPT PAPER
FAMILY COVERAGE DEMONSTRATION**

October 13, 2000

**State of Washington
Department of Social & Health Services
Governor's Executive Policy Office
Health Care Authority**

A. INTRODUCTION

This concept paper provides an overview of Washington State's forthcoming Section 1115(a) demonstration request to waive provisions in Title XXI of the Social Security Act to allow Washington to offer state subsidized health coverage to the adult family members of children receiving Medicaid or State Children's Health Insurance Program (SCHIP) coverage. The demonstration would expand affordable health coverage to families with incomes up to 250% of the federal poverty guideline (FPG). Family coverage would be provided through Washington's existing state Medicaid, SCHIP and Basic Health (BH) health care systems. The adult members' coverage would be financed through the state's residual Title XXI allotment and the state's Health Services Account (HSA), which also is used to finance the Medicaid Children's Medical Program, SCHIP and subsidized BH program. Washington would like to begin offering this family coverage beginning January 2002.

Washington's 1115 family coverage demonstration will be consistent with President Clinton's FFY 2001 budget proposal for a new health insurance coverage initiative called FamilyCare. The demonstration also will meet the requirements set forth in the Health Care Financing Administration's (HCFA) July 31, 2000, letter on SCHIP demonstration projects. This demonstration would reduce the number of low-income adults who are without health insurance and increase the coverage of their children by enabling entire families to receive health care through the same programs.

Under the Washington family coverage proposal, adult family members would be insured to the extent possible in the same managed care plan as their children to promote continuity of care and administrative simplicity. The adult family members would receive BH benefit coverage, and their children would receive Basic Health Plus (BH+) coverage, which is the same as Medicaid/SCHIP coverage.

Washington's Title XXI allotment would first be prioritized to cover uninsured children between 200% and 250% of FPG. The state's Medicaid program already covers children up to 200% of FPG. The state's residual Title XXI allotment would then be used to cover parent and guardians with Medicaid or SCHIP children between 0% and 250% of FPG for families enrolled in BH.

B. STATE SUBSIDIZED COVERAGE FOR CHILDREN & FAMILIES

Washington State has been a national leader in providing health care coverage to children and families. Following is a description of the state's efforts in providing this coverage. The programs and delivery systems described in this section will be those used to expand family coverage through the 1115 SCHIP family coverage demonstration waiver.

1. Children's Medicaid Program

In the late 1980s, Washington began to implement a series of medical care coverage expansions for children. In 1989, the State Legislature enacted the Maternity Care Access Act of 1989. This act authorized the Department of Social and Health Services (DSHS) to expand Medicaid coverage and comprehensive prenatal

State of Washington
SCHIP Annual Report
January 31, 2001

care coverage to pregnant women and infants with incomes up to 185% of FPG.

The program has achieved a significant reduction in inadequate prenatal care rates, low birth weights and infant mortality rates among Medicaid women.

In January 1991, DSHS implemented the Children's Health Program to provide coverage to children under age 18 who were in households with income up to 100% of FPG. The state's Medicaid program was already covering children through age 5 in households up to 133% of FPG. The Children's Health Program was converted to Medicaid funding in January 1992, and the age limit was raised through age 18. Children not meeting Medicaid citizenship requirements continue to receive coverage through the Children's Health Program.

In July 1994, the Medicaid children's program was further expanded to 200% of FPG. The program was later named Children's Medical Program. Prior to enactment of SCHIP, Washington was one of only four states with coverage at or above SCHIP's target of 200% of FPG.

The Children's Medical Program coverage has grown significantly. Currently, the program is covering 280,000 children. In total, the various Medical Assistance programs (TANF, CN Blind & Disabled, Children's Health Program, and Children's Medical program) cover some 496,000 children. Medicaid is the largest health insurer of children, and is covering 31% of all children in the state.

Based on the most currently available data, Washington's 1998 children's overall uninsured rate was 7.8%.² The rate for children below 200% of FPG was 14.1% and 8.7% for children between 200% and 250% of FPG. The Urban Institute's 1997 National Survey of America's Families reported that Washington's 1997 children's uninsured rate ranked 5th among a sample of 13 key states. The national rate was 11.9%. Given its long history of providing low-income children's coverage, Washington had the lowest uninsured rate for children below 200% of FPG among the 13 states surveyed – 12.1% compared to the national rate of 21.3%.³

In spite of expansion efforts, an estimated 70,000 low-income children remain uninsured. To address this issue, DSHS implemented a Medicaid outreach project in 1999 using partnerships with local governmental entities, tribes and private organizations. Currently, DSHS is contracting with 34 community-based organizations in 35 of the state's 39 counties.

Based on current forecasts, it is estimated that the Medicaid Children's Medical Program will increase about 5.5% per year during the 2001-2003 biennium, and will cover about 317,000 by June 2003. In total, DSHS will cover some 527,000 children - 32% of the total state's children's population.

Coverage for children and families is provided primarily through the Healthy Options (HO) program. Fully implemented statewide in 1995, HO is a managed care program, in which DSHS contracts with licensed health carriers to offer comprehensive medical coverage. Nine carriers currently provide HO coverage in all 39 counties of the state. Certain services, such as dental care and eyeglasses, are covered through fee-for-service (FFS). Mental health inpatient and community-based coverage is provided separately through a local, governmental-based, Regional Support Network delivery system.

2 Source: Washington State's Office of Financial Management conducts a biennial Washington State Population Survey (WSPS). The data used in this concept paper is from the 1998 WSPS. Preliminary 2000 WSPS data will be available in October 2000.

3 Source: Health Status of Non-elderly Adults and Children, Zuckerman, Stephen and Norton Stephen, National Survey of America's Families, The Urban Institute, Assessing the New Federalism (November 1997).

2. State Children's Health Insurance Program

As outlined above, Washington was one of only four states with children's coverage at or above the SCHIP target income level of 200% of FPG prior to enactment of SCHIP. In 1999, the Washington State Legislature appropriated funds to finance Governor Locke's request to implement SCHIP coverage for 10,000 children up to 250% of FPG. Program coverage began in February 2000. October's enrollment has reached 2,300 children.

Washington's SCHIP is a non-entitlement Medicaid "look-alike" program. The legislature authorized funding to cover 10,000 children. SCHIP has the same full-scope benefit design as the Medicaid Children's Medical Program. Unlike the Medicaid program, SCHIP has \$5 copayments for office visits (no copayments for preventive services), \$5 copayments for brand name prescription drugs and \$25 copayments for emergency room visits (waived if admitted for inpatient care). Families also are required to pay monthly premiums (\$10 per child, \$30 family maximum) with an annual out of pocket maximum based on family size.

The Children's Medical Program and SCHIP have the same eligibility standards, except for income levels. There are no resource requirements. Both programs use the same 2-page application form. Applications can be either by mail or through DSHS' local Community Services Offices (CSO). Face-to-face interviews are not required. Both programs have 12-month continuous eligibility. Families can convert from one program to the other as income changes through telephone contact with DSHS's centralized Medical Eligibility Determination Services (MEDS).

SCHIP coverage is offered through both HO contractors and FFS providers. For CY 2001, at least one of three HO contractors will be offering SCHIP in 33 counties. Managed care coverage is voluntary except in 6 counties with two plans. DSHS will be reviewing whether to require all HO bidders to also bid for SCHIP children in CY 2002.

3. Basic Health Program

In addition to children's coverage, Washington also has been a national leader in offering innovative health care coverage to families and individuals through the BH program. Based on a 1986 study by the Washington Health Care Project Commission, the 1987 State Legislature enacted legislation and funding for BH and the Washington State Health Insurance Pool (WSHIP). BH was implemented in 1988 as a managed care demonstration project. The legislature originally gave funding authority to cover up to 22,000 residents with incomes up to 200% of FPG.

As part of its 1993 comprehensive health reform legislation, the legislature expanded BH into a permanent program, lifted the enrollment cap, and merged it with the state's Health Care Authority (HCA), which is responsible for purchasing health care insurance for state employees and other local governmental employees. The legislature also created the Health Services Account (HSA) to fund BH, public health and other health initiatives.

In 1995, coverage was expanded to include coverage for mental health, chemical dependency and organ transplants. Funding also was provided to reduce BH premiums to \$10 per month for persons below 125% of State of Washington
SCHIP Annual Report
January 31, 2001

FPG. Nearly 130,000 residents annually received subsidized BH coverage from October 1996 through 2000.

BH offers a benefit plan that includes: hospital care; emergency care; medical and surgical care; organ transplants; preventive care; maternity care through Medicaid; plastic and reconstructive services; pharmacy benefits; mental health services; chemical dependency services; durable medical equipment and medical supplies in certain situations; short-term skilled nursing and home care benefits as an alternative to hospitalization in an acute care facility; and hospice services. BH coverage does not cover the entire scope of medical benefits offered under Medicaid, including: vision care; speech, occupational and physical therapy; and dental coverage.

BH has copayment requirements except for preventive care, lab and x-ray, and emergency use of outpatient facilities. Enrollees are required to pay monthly premiums based on an eight-tier schedule, based on household income.

Like Medicaid, HCA contracts with licensed health carriers to offer BH coverage. Currently, there are 9 carriers offering coverage in all 39 counties of the state. Although not a contract requirement, 7 carriers contract for both BH and HO coverage.

Although health care costs have increased at a greater rate than HSA revenue growth, the 1999 legislature authorized funding to cover 133,000 BH enrollment slots for the 1999-2001 biennium. The 2000 legislature enacted legislation that would allow BH to increase the allowable income level up to 250% of FPG if federal funding is made available to help finance the expansion.

HCA and DSHS have undertaken a number of initiatives to create seamless coverage for families eligible for BH and Medicaid coverage. In 1994, the agencies implemented Basic Health Plus (BH+), whereby Medicaid eligible children with BH parents could be in the same managed care plan as their parents and receive free, full-scope Medicaid coverage. HCA contracts for both BH and BH+ coverage and receives Medicaid payments from DSHS for the children's coverage. The two agencies coordinate eligibility so that families only have to apply through HCA to obtain BH and BH+ coverage. Currently there are 55,000 Medicaid children in BH+. In addition, pregnant women receive free, full-scope Medicaid medical and prenatal care coverage through their BH plan for up to 60-days post partum.

4. Health Services Account.

As part of the Washington's 1993 comprehensive health reform initiative, the legislature created the Health Services Account (HSA). The account can only be used for maintaining and expanding state subsidized health care coverage for low income residents, maintaining and expanding the public health system, and maintaining and expanding the state's health care system. Currently, HSA funds are used to finance subsidized BH coverage for a targeted 133,000 slots, finance the SCHIP for a targeted 10,000 slots, serve as the state matching fund source for the Children's Medical Program, finance the state's public health improvement plan initiatives, and provide funding for additional school nurses to targeted areas.

HSA is a dedicated account, which is not funded through the State General Fund. Revenue for the account comes from dedicated taxes on alcohol and tobacco products, elimination of tax exemptions on public hospitals and health care plan premiums, and the state's payments from the national 1999 Tobacco Settlement.

C. FAMILY COVERAGE PROPOSAL

Washington State will be requesting a Section 1115(a) demonstration waiver to use its residual Title XXI allotment to cover parents and guardians of children who are eligible for Medicaid or SCHIP coverage. The Title XXI funds would be used to expand BH coverage up to 250% of FPG to cover the parents and guardians of SCHIP children. The funds also would be used to cover existing BH parents and guardians with Medicaid funded BH+ children in households below 200% of FPG, and new BH parents and guardians with BH+ children. Title XXI funds would not be used to cover parents or guardians enrolled in the state's current Medicaid program.

As part of a second-phase, Washington would explore strategies to cover families of Medicaid and SCHIP eligible children through parents and guardians with employers that offer health coverage. The purpose of this initiative would be to provide families with more coverage options, develop more cost-effective coverage options, and support employer efforts to offer health coverage.

1. Benefit Coverage

The SCHIP family coverage demonstration would use the state's existing benefit designs. All children would continue to be eligible for full-scope Medicaid and SCHIP coverage. Medicaid eligible children would not be subject to copayments, while SCHIP eligible children would be subject to existing SCHIP copayment requirements described above.

The parents and guardians would be eligible for BH coverage. This would include a 9-month pre-existing condition limitation. They also would be subject to existing BH copayment requirements. Exhibit 1 lists BH's schedule of benefits. In developing employer-sponsored options, Washington would like to explore options that would allow employers to certify that they have a "standard" benefit package that would meet the state's coverage requirements.

2. Premiums

The SCHIP family coverage demonstration would use the state's existing premium schedules. Medicaid children would not have any premium requirements. The SCHIP children would have the same requirements as under the existing SCHIP program.

The parents and guardians would be subject to the existing BH requirements. Exhibit 2 has examples of the existing BH premium requirements for its benchmark plan. Parents and guardians also would have to pay the difference between the benchmark and higher priced plan if they selected that plan.

3. Eligibility

The details of eligibility standards and application processing for the family care proposal have not been determined. Consistent with the "seamless system" efforts described above for BH+ children, DSHS and HCA program administration and coordination of family coverage would continue to be strengthened. It is envisioned that a user-friendly and effective process for application and eligibility determination would be developed.

D. DEMONSTRATION OBJECTIVES

Washington State's family coverage project would demonstrate whether offering family coverage would increase coverage for low-income families with relatively higher income. It would be a unique project in that family coverage would be offered through BH, which would be a non-Medicaid/SCHIP program. BH is already serving some 132,000 persons. The specific evaluation objectives would include:

- Does offering coverage to the entire family increase children's SCHIP enrollment.
- Does offering coverage to the entire family increase higher income Medicaid enrollment of children.
- Are there better health outcomes (e.g., immunization rates, CAHPS utilization measures) for children whose parents have health insurance compared to Medicaid/SCHIP children whose parents don't have coverage.
- Develop new strategies to enhance coordination of coverage between Medicaid/SCHIP programs and other state-funded coverage.
- Develop new strategies to provide subsidized coverage for families through their employer sponsored health program.
- Decrease the state's proportion of the uninsured population below 250% of FPG.

Washington also would welcome demonstration objectives that HCFA would want to address as it develops strategies to further support the goals of the SCHIP program.

E. QUALIFYING ASSURANCES

In its July 31, 2000, letter on SCHIP Section 1115 Demonstration Policy, the Health Care Financing Administration (HCFA) outlined a set of assurances to qualify for a demonstration. Washington State is already or will be in compliance with these assurances by the demonstration implementation date. As described above, Washington has been covering eligible children through age 18 in households up to 200% of FPG through its Medicaid program since July 1994. As a Medicaid program, children's coverage is statewide, and there are no waiting lists or enrollment restrictions.

Both its Medicaid and SCHIP programs use the same mail-in application form and have the same application procedures. Neither the Medicaid children's program nor SCHIP have any resource tests. The programs have 12-month continuous eligibility. Applications and renewals are by mail and do not require face-to-face interviews.

Washington's family coverage would be available to families with Medicaid or SCHIP eligible children, in households up to 250% of FPG. Priority coverage will not be given to higher income families. Coverage will be on a first come, first serve basis. However, enrollment will be limited to available Title XXI and HSA funds. Also, Title XXI funds would first be prioritized to cover SCHIP children.

F. ALLOTMENT NEUTRALITY

Washington's family coverage demonstration would meet Title XXI budget neutrality requirements by spending no more in Title XXI funds than its annual Title XXI allotment for both its existing SCHIP and family coverage demonstration.

Washington's SCHIP allotments are: \$46.67 million for FFY 1998; \$46.44 for FFY 1999; and \$52.36 million for FFY 2000. Based on the budget submitted with its SCHIP State Plan, Washington's preliminary estimated allotment draws are: \$2.2 million for FFY 2000; \$7.5 million for FFY 2001; and \$8.8 million for FFY 2002. Without proposed changes in federal law (S.2434 or H.R.4393), Washington must return \$44 million of its FFY 1998 allotment and \$39 million of its FFY 1999 allotment. Washington's family coverage would be limited to the residual Title XXI funds within the given 3-year use period.

G. MAINTENANCE OF EFFORT

The expanded coverage of adult family members of children receiving either Medicaid or SCHIP coverage under the family coverage proposal will not supplant funds intended for children's coverage under Title XXI. The state's Title XXI allotment will first be prioritized to cover SCHIP children. Residual Title XXI funds will then be allocated to BH coverage for parents or guardians of Medicaid or SCHIP children.

As described above, state funding for SCHIP, the Medicaid children's program and BH is currently through the Health Services Account (HSA) that was established in 1993 as part of the state's comprehensive health reform initiative. The HSA is currently used to finance the subsidized BH program, Medicaid Children's Medical Program, SCHIP, school nurse expansion administered by the state's Office of Superintendent of Public Instruction (OSPI), and various public health initiatives administered through the state's Department of Health (DOH).

Under the family coverage demonstration, Washington State assures it will maintain its current HSA funding level for BH coverage. This commitment will provide funding to ensure full coverage of SCHIP children, expand BH coverage to parent and guardians up to 250% of FPG, and provide more BH capacity to cover new BH members with income below 250% FPG who are seeking family coverage.

EXHIBIT 1

BASIC HEALTH PROGRAM – SCHEDULE OF BENEFITS

BASIC HEALTH BENEFITS

This information is a brief summary of Basic Health benefits for reduced-premium members. For specifics, see the "Schedule of Benefits" in the Basic Health *Member Handbook*, which you'll receive about a month after you enroll, or call 1-800-842-7712 for recorded information. The Member Handbook is also available on our Web site (www.wa.gov/hca/basichealth.htm). Full-premium members should refer to the *Amendment to the Basic Health Member Handbook for Full-Premium Members* for benefits information.

To obtain benefits, you must see your health plan's authorized providers (doctors and facilities). Your health plan will also require that your care be coordinated or performed by your primary care provider. For more information, see "How the Health Plans Work" on page 12.

Emergency care does not require prior approval from your primary care provider. However, you must report it to your primary care provider within 24 hours or as soon as possible. Any other care not approved by your health plan is not covered under Basic Health. If you receive care that's not covered under Basic Health, you must pay the entire cost for those services. Some benefits described in this booklet are based on state laws. We have attempted to describe them accurately, but if there are differences, the laws will govern.

Benefits	Copayments	For Your Information
Office visits	\$10/visit	No copayment for maternity care or routine physical exam
Hospital stays	\$100/admission; maximum of \$500/member in a calendar year	No copayment for maternity care or readmission for the same condition within 90 days
Emergency room	\$50/visit (\$0 if you're admitted)	You're covered for emergencies, even when you're out of the state (see page 18 for definition of emergency)
Ambulance services	\$50/transport	Includes approved transfers from one facility to another; no copayment if transfer is required by the health plan, or if necessary for enrollee to receive services
Radiology/laboratory	No copayment	Includes ultrasound and nuclear medicine
Preventive care	No copayment	Includes routine physicals, immunizations, Pap tests, mammograms, and other screening services, when appropriate.

Benefits	Copayments	For Your Information
Maternity services*	No copayment	Maternity benefits for eligible members are provided through the Maternity Benefits Program; includes full prenatal care, delivery, post-partum care, care for pregnancy complications and termination of pregnancy.
Pharmacy**	Tier 1: \$1 Tier 2: \$5 Tier 3: 50%	You receive up to a 30 day supply/prescription
Out-of-area emergency services	\$50/visit	When you are out of your health plan's service areas, Basic Health covers only emergency care; you must notify your health plan within 24 hours of receiving care, or as soon as reasonably possible.
Skilled nursing, hospice, and home health care	No copayment	Covered as an alternative to hospital care at the health plan's discretion.
Organ transplants	\$100/admission; \$10/outpatient visit	12-month waiting period, except for newborns or for a condition that is not pre-existing (see page 19 for definition)
Chemical dependency	\$100/admission; \$10/outpatient visit	Limited to \$5,000 every 24 month period; \$10,000 lifetime maximum
Mental health	\$100/admission; \$10/outpatient visit	Limited to 10 inpatient days a year and 12 outpatient visits a year; doctor visits to manage medications do not count toward the 12-visit maximum
<p>* See page 10 for details</p> <p>** Different health plans have different formularies (lists of approved prescription drugs). The prescription drugs listed in each tier may also vary.</p> <p>Examples of the medicines in each tier are: Tier 1, prenatal vitamins, amoxicillin and insulin; Tier 2, generic drugs in the health plan's formulary that aren't in Tier 1; Tier 3, brand-name drugs. To find out if a specific medicine will be covered, contact the health plan directly.</p>		

BASIC HEALTH EXCLUSIONS

The services listed below are not covered:

1. Services that do not meet coverage criteria (as explained in the *Member Handbook*) for the diagnosis, treatment, or prevention of injury or illness, or to improve the functioning of a malformed body member, even though such services are not specifically listed as exclusions.
2. Services not provided, ordered, or authorized by the enrollee's health plan or its contracting providers, except in an emergency.
3. Services received before the enrollee's effective date of coverage.
4. Custodial care, domiciliary care, or rest cures for which facilities of an acute care general hospital are not medically required. Custodial care is care that does not require the regular services of trained medical or allied health care professionals, and that is primarily to assist in activities of daily living, such as help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications which are ordinarily self-administered.
5. Hospital charges for personal comfort items; or a private room unless authorized by the enrollee's health plan; or services such as telephones, televisions and guest trays.
6. Emergency facility services for nonemergency conditions.
7. Charges for missed appointments or for failure to provide timely notice for cancellation of appointments; charges for completing or copying forms or records.
8. Transportation except as specified under "Organ Transplants" and "Emergency Care" in the *Member Handbook*.
9. Implants, except; cardiac devices, artificial joints, intraocular lenses (limited to the first intraocular lens following cataract surgery) and implants as defined in the "Plastic and Reconstructive Surgery" benefit in the *Member Handbook*.
10. Sex change operations; investigation of or treatment for infertility or impotence; reversal of sterilization; artificial insemination; in-vitro fertilization.
11. Eyeglasses, contact lenses (except for the first intraocular lens following cataract surgery); routine eye exams, including eye refraction, except as part of a routine exam under "Preventive Care" as explained in the *Member Handbook*; and hearing aids.
12. Orthopedic shoes and routine foot care.

13. Speech, occupational, and physical therapy.

14. Medical equipment or supplies not specifically listed in the *Member Handbook* (including but not limited to hospital beds, wheelchairs, walk aids, respiratory equipment and oxygen) except:
 - a) While the enrollee is in the hospital, or;
 - b) When a provider contracted with the enrollee's health plan requests prior approval of a service, supply, or equipment. The health plan may limit approval to those situations where, in its sole judgment, it is expected that coverage will result in a lower total out-of-pocket cost to the health plan if the enrollee were to stay in Basic Health and the health plan for a subsequent four (4) years.
15. Dental services, including orthodontic appliances and services for temporomandibular joint problems, except for repair required because of accidental injury to sound natural teeth or jaw, provided that such repair begins within ninety (90) days of the accidental injury or as soon thereafter as is medically feasible, provided the enrollee is eligible for covered services at the time that services are provided.
16. Obesity treatment and weight-loss programs.
17. Cosmetic surgery, including treatment for complications of cosmetic surgery, except as described in the *Member Handbook*.
18. Medical services received from or paid for by the Veterans Administration or by state or local government, except where in conflict with the Revised Code of Washington or federal law. Benefits to the extent that benefits are payable under the terms of any insurance policy issued to, or which provides benefits for, an enrollee where the policy provides payment toward medical expenses without a determination of liability.
19. Conditions resulting from acts of war (declared or not).
20. Any service or supply not specifically listed as a covered service, unless prescribed by a contracting provider and authorized by the health plan.

WAITING PERIODS

Pre-Existing Conditions

You must wait nine months from the day your coverage begins before Basic Health will cover pre-existing conditions (see page 19 for definition), except for maternity care and prescription drugs.

If you had coverage similar to Basic Health coverage (including Healthy Options or other Medical Assistance coverage) any time in the three months just before you applied for or were enrolled in Basic Health, your waiting period for treatment of a pre-existing condition will be shorter. The table below gives examples of how this works.

Waiting Period for Organ Transplant Procedures

You must be enrolled in Basic Health for 12 consecutive months before you're covered for organ transplant procedures unless:

- The transplant is for a condition that was not pre-existing; or
- The transplant is for a child enrolled in and continuously covered by Basic Health from the date of birth; or
- The transplant is for a child placed for adoption in the home of a Basic Health member within 60 days of birth and is continuously covered by Basic Health from the date of placement, if one or both of the adoptive parents were enrolled in Basic Health when the child was placed.

Basic Health *Plus*

Children enrolled in Basic Health *Plus* have no waiting period for pre-existing conditions.

	Months credited toward the three-month waiting period for pre-existing conditions .
Continuous coverage in effect within three months of either the date Basic Health receives your application or the date your coverage begins.	One month credit for each month of continuous coverage.
Coverage during both the three months before your application was received and the three months before your coverage begins, with a break in coverage.	One month credit for each month of continuous coverage during the longer of the two coverage periods. For example, if you had three months continuous coverage before your application date and two months coverage before your Basic Health coverage began, credit would be given for three months coverage.

EXHIBIT 2

BASIC HEALTH PROGRAM – PREMIUM SCHEDULE

Basic Health Plan Subsidized Rates Charged to Subscribers

Final 2001 Rates

HCA Finance and Administration

		<u>Income</u>								
		<u>Band A</u>	<u>Band B</u>	<u>Band C</u>	<u>Band D</u>	<u>Band E</u>	<u>Band F</u>	<u>Band G</u>	<u>Band H</u>	
		less than 65% FPL	greater than or equal to 65% FPL and less than 100% FPL	greater than or equal to 100% FPL and less than 125% FPL	greater than or equal to 125% FPL and less than 140% FPL	greater than or equal to 140% FPL and less than 155% FPL	greater than or equal to 155% FPL and less than 170% FPL	greater than or equal to 170% FPL and less than 185% FPL	greater than or equal to 185% FPL and less than or equal to 200% FPL	
<u>Age Group</u>	<u>Plan</u>									
<u>1 Child</u>	Aetna USHC of WA	\$ 23.19	\$ 27.19	\$ 30.69	\$ 30.69	\$ 30.69	\$ 32.63	\$ 37.81	\$ 43.00	
	Community Health Plan of WA	\$ 10.00	\$ 14.00	\$ 17.50	\$ 17.50	\$ 17.50	\$ 19.44	\$ 24.62	\$ 29.81	
	Columbia United Providers	\$ 14.20	\$ 18.20	\$ 21.70	\$ 21.70	\$ 21.70	\$ 23.64	\$ 28.82	\$ 34.01	
	Group Health Coop. Puget Sound	\$ 15.24	\$ 19.24	\$ 22.74	\$ 22.74	\$ 22.74	\$ 24.68	\$ 29.86	\$ 35.05	
	Kaiser Foundation Health Plan	\$ 23.27	\$ 27.27	\$ 30.77	\$ 30.77	\$ 30.77	\$ 32.71	\$ 37.89	\$ 43.08	
	Northwest WA Medical Bureau	\$ 24.73	\$ 28.73	\$ 32.23	\$ 32.23	\$ 32.23	\$ 34.17	\$ 39.35	\$ 44.54	
	Premera Blue Cross	\$ 18.39	\$ 22.39	\$ 25.89	\$ 25.89	\$ 25.89	\$ 27.83	\$ 33.01	\$ 38.20	
	Molina Healthcare of Washington, Inc.	\$ 17.85	\$ 21.85	\$ 25.35	\$ 25.35	\$ 25.35	\$ 27.29	\$ 32.47	\$ 37.66	
	Regence Blue Shield	\$ 26.24	\$ 30.24	\$ 33.74	\$ 33.74	\$ 33.74	\$ 35.68	\$ 40.86	\$ 46.05	
<u>2 Children</u>	Aetna USHC of WA	\$ 46.38	\$ 54.38	\$ 61.38	\$ 61.38	\$ 61.38	\$ 65.26	\$ 75.62	\$ 86.00	
	Community Health Plan of WA	\$ 20.00	\$ 28.00	\$ 35.00	\$ 35.00	\$ 35.00	\$ 38.88	\$ 49.24	\$ 59.62	
	Columbia United Providers	\$ 28.40	\$ 36.40	\$ 43.40	\$ 43.40	\$ 43.40	\$ 47.28	\$ 57.64	\$ 68.02	
	Group Health Coop. Puget Sound	\$ 30.48	\$ 38.48	\$ 45.48	\$ 45.48	\$ 45.48	\$ 49.36	\$ 59.72	\$ 70.10	
	Kaiser Foundation Health Plan	\$ 46.54	\$ 54.54	\$ 61.54	\$ 61.54	\$ 61.54	\$ 65.42	\$ 75.78	\$ 86.16	
	Northwest WA Medical Bureau	\$ 49.46	\$ 57.46	\$ 64.46	\$ 64.46	\$ 64.46	\$ 68.34	\$ 78.70	\$ 89.08	
	Premera Blue Cross	\$ 36.78	\$ 44.78	\$ 51.78	\$ 51.78	\$ 51.78	\$ 55.66	\$ 66.02	\$ 76.40	
	Molina Healthcare of Washington, Inc.	\$ 35.70	\$ 43.70	\$ 50.70	\$ 50.70	\$ 50.70	\$ 54.58	\$ 64.94	\$ 75.32	
	Regence Blue Shield	\$ 52.48	\$ 60.48	\$ 67.48	\$ 67.48	\$ 67.48	\$ 71.36	\$ 81.72	\$ 92.10	
<u>3+ Children</u>	Aetna USHC of WA	\$ 69.57	\$ 81.57	\$ 92.07	\$ 92.07	\$ 92.07	\$ 97.89	\$ 113.43	\$ 129.00	
	Community Health Plan of WA	\$ 30.00	\$ 42.00	\$ 52.50	\$ 52.50	\$ 52.50	\$ 58.32	\$ 73.86	\$ 89.43	
	Columbia United Providers	\$ 42.60	\$ 54.60	\$ 65.10	\$ 65.10	\$ 65.10	\$ 70.92	\$ 86.46	\$ 102.03	
	Group Health Coop. Puget Sound	\$ 45.72	\$ 57.72	\$ 68.22	\$ 68.22	\$ 68.22	\$ 74.04	\$ 89.58	\$ 105.15	
	Kaiser Foundation Health Plan	\$ 69.81	\$ 81.81	\$ 92.31	\$ 92.31	\$ 92.31	\$ 98.13	\$ 113.67	\$ 129.24	
	Northwest WA Medical Bureau	\$ 74.19	\$ 86.19	\$ 96.69	\$ 96.69	\$ 96.69	\$ 102.51	\$ 118.05	\$ 133.62	
	Premera Blue Cross	\$ 55.17	\$ 67.17	\$ 77.67	\$ 77.67	\$ 77.67	\$ 83.49	\$ 99.03	\$ 114.60	
	Molina Healthcare of Washington, Inc.	\$ 53.55	\$ 65.55	\$ 76.05	\$ 76.05	\$ 76.05	\$ 81.87	\$ 97.41	\$ 112.98	

Basic Health Plan Subsidized Rates Charged to Subscribers

Final 2001 Rates

HCA Finance and Administration

		<u>Income</u>								
		<u>Band A</u>	<u>Band B</u>	<u>Band C</u>	<u>Band D</u>	<u>Band E</u>	<u>Band F</u>	<u>Band G</u>	<u>Band H</u>	
		less than 65% FPL	greater than or equal to 65% FPL and less than 100% FPL	greater than or equal to 100% FPL and less than 125% FPL	greater than or equal to 125% FPL and less than 140% FPL	greater than or equal to 140% FPL and less than 155% FPL	greater than or equal to 155% FPL and less than 170% FPL	greater than or equal to 170% FPL and less than 185% FPL	greater than or equal to 185% FPL and less than or equal to 200% FPL	
<u>Age Group</u>	<u>Plan</u>									
<u>Age 0-39</u>	Regence Blue Shield	\$ 78.72	\$ 90.72	\$ 101.22	\$ 101.22	\$ 101.22	\$ 107.04	\$ 122.58	\$ 138.15	
	Aetna USHC of WA	\$ 36.36	\$ 40.36	\$ 43.86	\$ 45.80	\$ 56.17	\$ 65.24	\$ 75.60	\$ 85.97	
	Community Health Plan of WA	\$ 10.00	\$ 14.00	\$ 17.50	\$ 19.44	\$ 29.81	\$ 38.88	\$ 49.24	\$ 59.61	
	Columbia United Providers	\$ 18.39	\$ 22.39	\$ 25.89	\$ 27.83	\$ 38.20	\$ 47.27	\$ 57.63	\$ 68.00	
	Group Health Coop. Puget Sound	\$ 20.47	\$ 24.47	\$ 27.97	\$ 29.91	\$ 40.28	\$ 49.35	\$ 59.71	\$ 70.08	
	Kaiser Foundation Health Plan	\$ 36.53	\$ 40.53	\$ 44.03	\$ 45.97	\$ 56.34	\$ 65.41	\$ 75.77	\$ 86.14	
	Northwest WA Medical Bureau	\$ 39.44	\$ 43.44	\$ 46.94	\$ 48.88	\$ 59.25	\$ 68.32	\$ 78.68	\$ 89.05	
	Premera Blue Cross	\$ 26.76	\$ 30.76	\$ 34.26	\$ 36.20	\$ 46.57	\$ 55.64	\$ 66.00	\$ 76.37	
	Molina Healthcare of Washington, Inc.	\$ 25.69	\$ 29.69	\$ 33.19	\$ 35.13	\$ 45.50	\$ 54.57	\$ 64.93	\$ 75.30	
Regence Blue Shield	\$ 42.46	\$ 46.46	\$ 49.96	\$ 51.90	\$ 62.27	\$ 71.34	\$ 81.70	\$ 92.07		
<u>Age 40-54</u>	Aetna USHC of WA	\$ 43.80	\$ 47.80	\$ 51.30	\$ 58.72	\$ 72.01	\$ 83.64	\$ 96.93	\$ 110.22	
	Community Health Plan of WA	\$ 10.00	\$ 14.00	\$ 17.50	\$ 24.92	\$ 38.21	\$ 49.84	\$ 63.13	\$ 76.42	
	Columbia United Providers	\$ 20.76	\$ 24.76	\$ 28.26	\$ 35.68	\$ 48.97	\$ 60.60	\$ 73.89	\$ 87.18	
	Group Health Coop. Puget Sound	\$ 23.43	\$ 27.43	\$ 30.93	\$ 38.35	\$ 51.64	\$ 63.27	\$ 76.56	\$ 89.85	
	Kaiser Foundation Health Plan	\$ 44.01	\$ 48.01	\$ 51.51	\$ 58.93	\$ 72.22	\$ 83.85	\$ 97.14	\$ 110.43	
	Northwest WA Medical Bureau	\$ 47.75	\$ 51.75	\$ 55.25	\$ 62.67	\$ 75.96	\$ 87.59	\$ 100.88	\$ 114.17	
	Premera Blue Cross	\$ 31.49	\$ 35.49	\$ 38.99	\$ 46.41	\$ 59.70	\$ 71.33	\$ 84.62	\$ 97.91	
	Molina Healthcare of Washington, Inc.	\$ 30.12	\$ 34.12	\$ 37.62	\$ 45.04	\$ 58.33	\$ 69.96	\$ 83.25	\$ 96.54	
	Regence Blue Shield	\$ 51.62	\$ 55.62	\$ 59.12	\$ 66.54	\$ 79.83	\$ 91.46	\$ 104.75	\$ 118.04	
<u>Age 55-64</u>	Aetna USHC of WA	\$ 67.80	\$ 71.80	\$ 75.30	\$ 100.42	\$ 123.14	\$ 143.03	\$ 165.76	\$ 188.49	
	Community Health Plan of WA	\$ 10.00	\$ 14.00	\$ 17.50	\$ 42.62	\$ 65.34	\$ 85.23	\$ 107.96	\$ 130.69	
	Columbia United Providers	\$ 28.40	\$ 32.40	\$ 35.90	\$ 61.02	\$ 83.74	\$ 103.63	\$ 126.36	\$ 149.09	
	Group Health Coop. Puget Sound	\$ 32.96	\$ 36.96	\$ 40.46	\$ 65.58	\$ 88.30	\$ 108.19	\$ 130.92	\$ 153.65	
	Kaiser Foundation Health Plan	\$ 68.16	\$ 72.16	\$ 75.66	\$ 100.78	\$ 123.50	\$ 143.39	\$ 166.12	\$ 188.85	
	Northwest WA Medical Bureau	\$ 74.55	\$ 78.55	\$ 82.05	\$ 107.17	\$ 129.89	\$ 149.78	\$ 172.51	\$ 195.24	
	Premera Blue Cross	\$ 46.75	\$ 50.75	\$ 54.25	\$ 79.37	\$ 102.09	\$ 121.98	\$ 144.71	\$ 167.44	

Basic Health Plan Subsidized Rates Charged to Subscribers

Final 2001 Rates

HCA Finance and Administration

		<u>Income</u>							
<u>Age Group</u>	<u>Plan</u>	<u>Band A</u>	<u>Band B</u>	<u>Band C</u>	<u>Band D</u>	<u>Band E</u>	<u>Band F</u>	<u>Band G</u>	<u>Band H</u>
		less than 65% FPL	greater than or equal to 65% FPL and less than 100% FPL	greater than or equal to 100% FPL and less than 125% FPL	greater than or equal to 125% FPL and less than 140% FPL	greater than or equal to 140% FPL and less than 155% FPL	greater than or equal to 155% FPL and less than 170% FPL	greater than or equal to 170% FPL and less than 185% FPL	greater than or equal to 185% FPL and less than or equal to 200% FPL
<u>Age 65+ **</u>	Molina Healthcare of Washington, Inc.	\$ 44.40	\$ 48.40	\$ 51.90	\$ 77.02	\$ 99.74	\$ 119.63	\$ 142.36	\$ 165.09
	Regence Blue Shield	\$ 81.17	\$ 85.17	\$ 88.67	\$ 113.79	\$ 136.51	\$ 156.40	\$ 179.13	\$ 201.86
	Aetna USHC of WA	\$ 83.01	\$ 87.01	\$ 90.51	\$ 126.84	\$ 155.55	\$ 180.67	\$ 209.38	\$ 238.09
	Community Health Plan of WA	\$ 10.00	\$ 14.00	\$ 17.50	\$ 53.83	\$ 82.54	\$ 107.66	\$ 136.37	\$ 165.08
	Columbia United Providers	\$ 33.24	\$ 37.24	\$ 40.74	\$ 77.07	\$ 105.78	\$ 130.90	\$ 159.61	\$ 188.32
	Group Health Coop. Puget Sound	\$ 39.01	\$ 43.01	\$ 46.51	\$ 82.84	\$ 111.55	\$ 136.67	\$ 165.38	\$ 194.09
	Kaiser Foundation Health Plan	\$ 83.46	\$ 87.46	\$ 90.96	\$ 127.29	\$ 156.00	\$ 181.12	\$ 209.83	\$ 238.54
	Northwest WA Medical Bureau	\$ 91.54	\$ 95.54	\$ 99.04	\$ 135.37	\$ 164.08	\$ 189.20	\$ 217.91	\$ 246.62
	Premiera Blue Cross	\$ 56.42	\$ 60.42	\$ 63.92	\$ 100.25	\$ 128.96	\$ 154.08	\$ 182.79	\$ 211.50
	Molina Healthcare of Washington, Inc.	\$ 53.46	\$ 57.46	\$ 60.96	\$ 97.29	\$ 126.00	\$ 151.12	\$ 179.83	\$ 208.54
	Regence Blue Shield	\$ 99.90	\$ 103.90	\$ 107.40	\$ 143.73	\$ 172.44	\$ 197.56	\$ 226.27	\$ 254.98

** - Not Medicare eligible for free or purchased
Part A Medicare.